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**San Francisco  
Department of Public Health  
MCAH Program**

# **Community Health Assessment and Local Plan 2000-2005**

DOCUMENTS DEPT.

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This plan would not have been completed without the services of Community Assessment Research & Evaluation, Inc. and the participation of the MCAH staff, the MCAH Advisory Board, and all the people in the community who participated in the planning.

Dr. Patricia Evans was greatly appreciated. She saw a need and took on the task of data analysis.

A special thanks to Nuala Price, MCAH Executive Secretary, who had the patience, perseverance, and willingness to type numerous rewrites.



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## **EXECUTIVE SUMMARY**



## **EXECUTIVE SUMMARY**

### **Background**

The San Francisco Maternal, Child and Adolescent health assessment and plan is the culmination of years of health planning for children, youth and families. The planning occurred in a variety of settings; Department of Public Health planning committees, community agency planning groups, agency and community based organizations, and advisory committees. Specific examples of the planning groups: Department of Public Health's Children's Coordinating Council for Children, Youth and Families, Starting Points, a community policy and planning group for children 0-5, and the Maternal, Child and Adolescent Health Advisory Board, appointed by the Board of Supervisors and representative of the diversity in the lay and professional community of San Francisco.

San Francisco is a city/county of diverse populations. Ethnic minorities make-up approximately 60% of the population, but the children and youth population is only about 23% of the population. The birth rate has gradually decreased over the past five years with many families leaving the city.

### **The Planning Process**

The planning body was composed of Maternal and Child Health staff and members of the Adolescent Health Advisory Board. The mission of the group was to promote the health and well being of pregnant women, children and adolescents by identifying gaps in services, needs of specific communities and population groups at risk for adverse health outcomes. Focus groups were conducted with the planning group and targeted communities utilizing data from The Health and Well-Being of Children and Youth in San Francisco Report (Appendix I). The key quantitative findings were in the following areas:

**Perinatal**      86% of pregnant women enter prenatal care during the first trimester, but there is a difference in ethnic groups. In the African American population it is only 76%, and in the Hispanic population it is only 77%. Infant mortality is still high in the African American population.

**Access to Health Care**      Greatest problem for Hispanic population and the working poor.

**Immunization Rate**      To date the rate is only approximately 70% for children.

**Foster Care**      Out-of-home placement is the highest per capita in the state, and African Americans represent 72% of the group.

**STDs**      Youth 15-19 have the highest rate of chlamydia and gonorrhea in San Francisco.



<u>Dental</u>	Although San Francisco has fluoridated water, 66% of the children examined in public elementary schools had dental caries. This is reflective of the high immigrant population.
<u>Disparities</u>	Greater health problems in three communities. These communities have high concentrations of low-income, working poor, ethnic and racial minorities and immigrant populations.

The key qualitative findings from the community needs assessment and focus groups were:

- Environmental factors of air pollution, toxic buildings and soil contamination impact children's safety and health.
- There is a lack of affordable health care for the working poor and Hispanic population.
- There is insufficient dental health insurance coverage, including government subsidized programs.
- There is diminution of quality of service caused by culturally insensitive health care professionals, lengthy waits for service, followed by abbreviated medical examinations.
- The overall health of their communities would be improved through greater involvement of each community in addressing its health care issues.

### Recommendations

The assessment and plan will be utilized to establish the maternal and child health agenda for the next five years. It will assist in identifying where resources should be deployed to realize the most effective outcomes for the improvement of health for women, children and adolescents in San Francisco. The plan will be evaluated annually to adjust to changing trends in the health, political and social milieu and to changes at the state and federal level. Social impact, such as the high cost of living in San Francisco and welfare reform has caused many families to move out of the city, which is reflected in the decreased birth rate and the small percentage of children under the age of 18. The high cost of living is reflected in the increased number of homeless families and the level of poverty among children – 23%.

The quantitative and qualitative data obtained indicate that work should continue in areas previously identified in San Francisco MCAH plans:

- (1) Increase the percentage of African American and Latina women receiving early prenatal care.
- (2) Reduce African American low birth weight.
- (3) Reduce African American infant mortality rates.
- (4) Improve health status of adolescents.
- (5) Increase preventive dental services for children.
- (6) Improve access to health care for children.
- (7) Achieve immunization objective.







## **II. COMMUNITY HEALTH ASSESSMENT**

**A. Community Profile**

**B. Agency Capacity**

**C. Community and Health Systems**

**D. Health Status Indicators**

**E. Qualitative Data**



## II. COMMUNITY HEALTH ASSESSMENT

### A. Community Profile

San Francisco lies on the northern tip of a peninsula at the entrance to the San Francisco Bay and is bordered by the Pacific Ocean on the west, the Golden Gate Strait on the north, the San Francisco Bay on the east, and the San Bruno Mountains on the south. The city covers 129 square miles including a land area of 47 square miles. The islands of Alcatraz, Angel, Treasure and Yerba Buena are also part of San Francisco. San Francisco is a combined City and County form of government. It is a leading center of financial and international trade, tourism and manufacturing. San Francisco has one of the largest ports in the nation and is the fourth largest city in California, and the tenth most populated county.

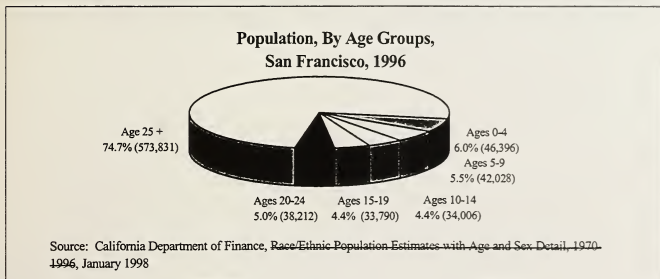
#### 1. Population

San Francisco consists of over 30 distinct neighborhoods, each of which has its own micro culture defined by diverse racial/ethnic groups and socioeconomic status.

San Francisco's population has increased from 723,959 in 1990 to an estimated population of 778,100 in 1997. The majority of residents are white (42%) followed by Asian/Pacific Islanders (32%), Hispanics (15%), Black 10%) and Native Americans (<1%).

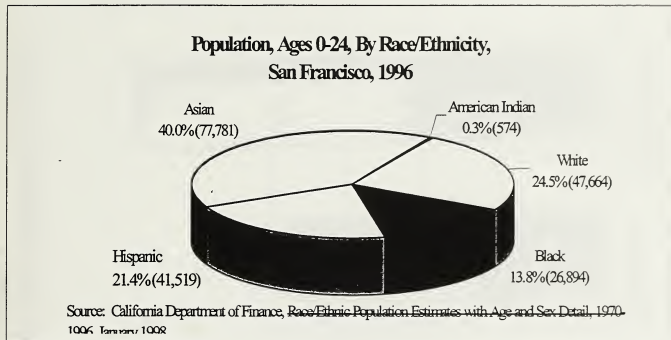
San Francisco has a distinct demographic profile with a smaller proportion of children and youth within the total population and a more racially/ethnically diverse population than the state of California. There was an estimated 194,432 children and youth ages 0-24, which comprises 25.5% of the city's population. The number of elderly has remained almost exactly the same over the seven-year period.

San Francisco ethnic groups comprises the largest population of children and youth ages 0-24: Asian/Pacific Islanders 40%, Caucasian 24.5%, Hispanic 21.4%, Blacks 13.8%, and American Indian 0.3%. San Francisco has a much larger percentage of Asian/Pacific Islanders and Black children and youth compared to the state while the state has a higher percentage of Hispanic children and youth. In general, non-White racial/ethnic groups in





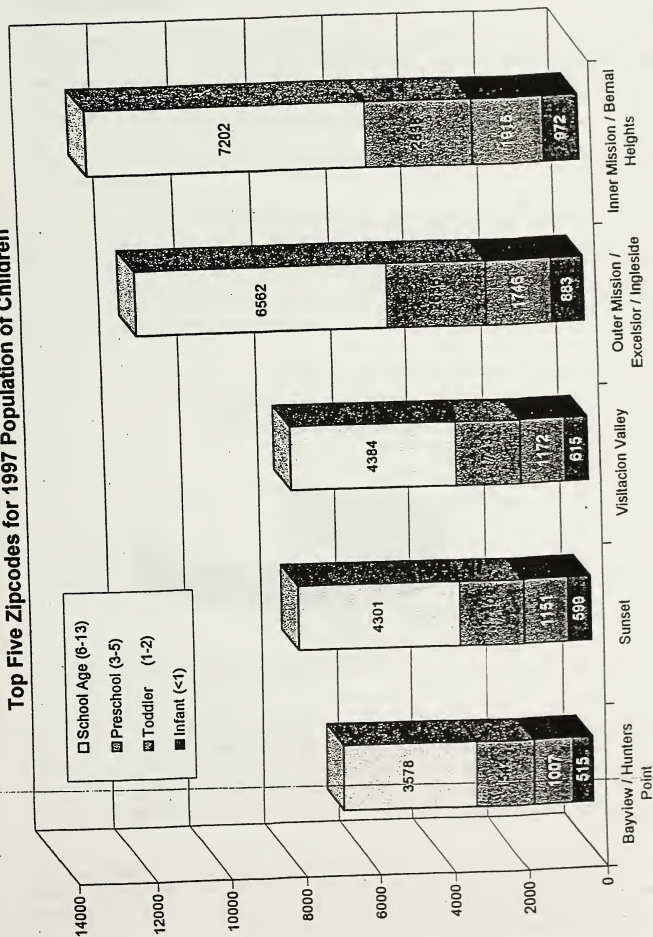
San Francisco tend to be relatively younger than the white population: Hispanic (35.2%), Black (34.9%), Asian/Pacific Islander (31.3%), American Indian (21.3%), and White (14.8%). Conversely, White's at 85.2% comprise a larger population of adults ages 25 and older compared to Asian/Pacific Islanders at 68.7%, Blacks at 65.1%, Hispanics at 64.8% and American Indians at 78.6%. The majority of children are located in five Zip Codes (Figure 3).



The measure of English proficiency is difficult to get data for but school data can be a source of information. San Francisco Unified School District data show that more than one in six students has limited English proficiency. The largest proportion of students with limited English speak Spanish and Cantonese. San Francisco has a large immigrant population. In 1996, San Francisco received 10,438 new immigrants, the sixth highest in the state. Countries of origin were China (25%), Philippines (13%), Hong Kong (6.80%), and Ukraine (5.7%).



**Figure 3**  
**Top Five Zipcodes for 1997 Population of Children**



Source: 1997 Population Projections (1990 Percentages Assigned to 1997 Current Population Projections, by Zipcode)



without health insurance compared to children in other racial/ethnic groups. In 1995, most uninsured children in California lived in families with at least one working parent, and children who are low-income are more likely to be uninsured. In 1997, about 29% of San Francisco's residents under age 21 received Medi-Cal, although there were wide variations across neighborhoods.

**Immunizations and Communicable Diseases:** San Francisco two-year olds had a 65% completion rate for immunizations in 1996, compared to a statewide rate of 57%. From 1990 to 1996, new reported cases of active tuberculosis among children and youth ages 0 to 18 represented 4% of all cases in the City. However, the rates among both children and adults are decreasing, similar to state and national trends. Nearly all (92%) new TB cases among children and youth were in non-White racial/ethnic groups.

**Sexual Behavior:** From 1992 to 1996, both chlamydia and gonorrhea rates declined substantially among San Francisco youth ages 15 to 19 and in San Franciscans of all age groups. However, youth ages 15 to 19 continue to have the highest rates of both chlamydia and gonorrhea, compared to all other age groups. Fifteen percent of San Francisco men who have sex with men (non-injection drug users) who are age 29 and under are estimated to be infected with HIV. Less than 1% (0.06%) of San Francisco infants and children age 13 or younger are estimated to be infected with HIV. Twelve percent of all AIDS cases in San Francisco are among children and youth and young adults up to age 29 which is less than the U.S. average (19%). The number of AIDS cases in this age group is declining. In 1997, 14% of San Francisco public middle school students and almost 30% of high school students reported that they engaged in sexual intercourse at least once in their lifetime.

**Mental Health:** From 1990 to 1995, suicide was the second leading cause of death for San Francisco youth ages 15 to 24. Nationally, suicide is the third leading cause of death for this age group. One quarter (24%) of San Francisco middle school students and 20% of San Francisco high school students said that they had seriously considered suicide.

**Oral Health:** San Francisco is the only 100%-fluoridated city and county in the State, achieving the Healthy People 2000 objective for fluoridation. However, 66% of public elementary school children in San Francisco had dental caries ("cavities") including about half that were untreated, compared to the Healthy People 2000 goal that less than 35% of children ages 6 to 8 have one or more caries which reflects the high immigrant population.

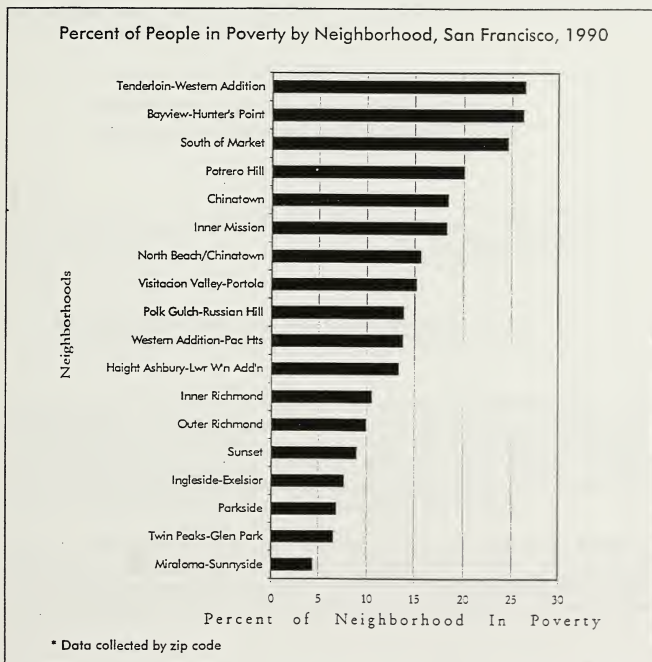
**Child Abuse and Neglect:** In 1995 there were 4,050 children and youth ages 0 to 17 in foster care. As of August 1998 there were 2,853. During the past three years there has been a 30% decrease in the number of children removed from their families and placed in foster care. San Francisco has the highest rate per capita in the state. Children and youth in foster care are 65% Black, 15% White, 9% Hispanic and 6% Asian. Forty-one percent of the children in foster care live with relative caregivers and 49% of those are out of county placements.



### 3. Socioeconomic Conditions

Poverty and socioeconomic conditions are important components of any assessment of children's and youth health because they have been shown to be associated with many types of poor health outcomes, poor nutrition, lack of access to adequate health care, and greater exposures to many kinds of physical, social, environmental, and behavioral risks.

Poverty is disproportionately concentrated among children, with the rate of poverty among children significantly higher than the rate in the overall population. In 1993, the poverty rate for San Franciscans of all ages was 13.5% compared to 22% for San Franciscans under the age of 18.

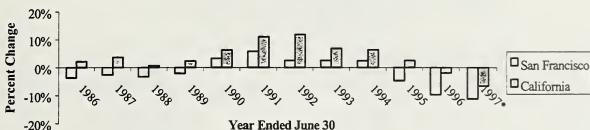




Unemployment rates are another key indicator of the economic status of a community. In 1997, San Francisco had the seventh lowest unemployment rate among California counties at 4%, well below the statewide average of 6.3%. Unemployment rates for youth are not available at the county level.

Another measure of socioeconomic conditions is the number of persons enrolled in entitlement programs. They can be a useful proxy indicator to track the magnitude and direction of poverty in the population. As of April 1998, there were 8,452 CalWORKS cases in San Francisco. The caseload had been declining since 1994 (13,091). Reasons for the decline in San Francisco include both economic recovery and the exodus of low-income residents because of a lack of affordable housing. Typically, about 80% of CalWORKS cases are single-parent families and about 20% two-parent families in which the principal wage earner is unemployed. Women head 90% of single-parent families, and 65% of recipients were children under the age of 19.

**CalWORKS, Percent Change in Average Monthly Caseload,\*  
San Francisco and California, Year Ending June 30, 1986-97**



Source: San Francisco Department of Human Services; California Department of Social Services

\*Note: San Francisco cases for 1996 to 1997 are for September 1996 and May 1997.

**Homelessness:** In 1996/97, the Connecting Point Housing Crisis Hotline received calls seeking assistance from 902 families with over 1,500 children of which half were age 5 or younger. Over a two-year period from 1995 to 1997, over 676 families were housed in and subsequently exited from one of the City's four largest family shelters. The three most common causes of homelessness as identified by the families were being evicted from their homes, substance abuse, and dangerous living environments.

**Crime:** In 1996, juveniles up to age 17 represented 8% of all arrests in San Francisco. The number of juvenile arrests declined by 26% from 1987 to 1996. The number of juvenile arrests for homicide has declined substantially by 1996 (8 arrests) from its peak in 1993 (34 arrests). Juvenile crime in San Francisco is concentrated in a few areas of the city.



## Education

In San Francisco about 70% (61,011) of school-age children are enrolled in public schools and 30% (25,995) are in private schools as compared to California which has 90% in public schools systems. Since 1991, San Francisco's high school graduation rates have been increasing with the current rate being 81.9%, slightly lower than the California rate of 83.1%. The racial/ethnic student population reflects the population: Chinese 27.3%, Hispanic 20.9%, Blacks 16.8%, White 12.7%, other non-White, Filipino 7.6%, Korean 1.1%, Japanese 1.1%, and Native American 0.7%

## Childcare

The need for childcare is a fact for many families of young children. Many families need two incomes to live in San Francisco, and Welfare Reform requires TANF families to either be in training or working. 57% of the children age 5 and under in San Francisco live with two working parents or one single employed parent. An estimated 51% of children ages 0-5 in San Francisco receive care outside of the home.

There are 625 licensed family day care providers in San Francisco who serve approximately 3,000 children.

### **Total Population (0-13) and Child Care Capacity, By Zipcode, San Francisco**

Zipcode	Neighborhood	Total Population	Licensed CC Slots	FCCH 8/14
94102	Hayes Valley / Tenderloin	3,193	641	32
94103	South of Market	2,075	504	24
94104	Financial District	77	36	0
94105	Downtown	59	206	0
94107	Potrero Hill	1,609	278	46
94108	Chinatown	1,042	482	8
94109	Russian Hill / Nob Hill	3,593	345	70
94110	Inner Mission / Bernal Heights	12,927	1,666	422
94111	Embarcadero / Gateway	83	56	8
94112	Outer Mission / Excelsior / Ingleside	11,827	853	588
94114	Castro / Noe Valley	2,014	312	98
94115	Pacific Heights	2,642	1,067	124
94116	Parkside / Forest Hill	5,386	883	398
94117	Haight / Western Addition / Fillmore	3,340	641	166
94118	Inner Richmond / Presidio / Laurel	4,873	1,242	214
94121	Outer Richmond / Sea Cliff	5,334	772	300
94122	Sunset	7,791	1,061	436
94123	Marina / Cow Hollow	1,423	478	148
94124	Bayview / Hunters Point	6,644	1,140	582
94127	West Portal / St. Francis Wood	2,703	444	162
94129	Presidio	542	229	0
94130	Treasure Island	680	0	0
94131	Twin Peaks / Diamond Heights / Glen	3,492	483	106
94132	Stonestown / Lake Merced	3,260	807	200
94133	North Beach / Telegraph Hill	2,742	544	64
94134	Visitation Valley	7,914	913	342
94143	Univ. of CA San Francisco	0	48	0
<b>TOTAL</b>		<b>97,265</b>	<b>16,131</b>	<b>4,538</b>



## **B. AGENCY CAPACITY**

### **B.1 Organizational Structure**

The Maternal Child Health Program in San Francisco County is part of the Children, Youth and Family Services Section of the Department of Public Health. The section also includes Children's Medical Services, WIC, Family Planning, Ear Center Program, and the Children's Dental Program. This structure promotes a comprehensive continuum of services for women and children from preconception through adolescence. It allows an opportunity for the advancement of prevention and early intervention that will ultimately lead to a healthier population.

### **B.2 MCAH Director Responsibilities**

The MCAH Director administers the Children, Youth and Family Services Section with the support of designated program managers. The Department of Public Health reorganized two years ago separating the delivery systems which provides individual clinical services from the regulatory and population based services. The Children, Youth and Family Services Section is in the population based branch of the Department. (See Organizational Chart.)

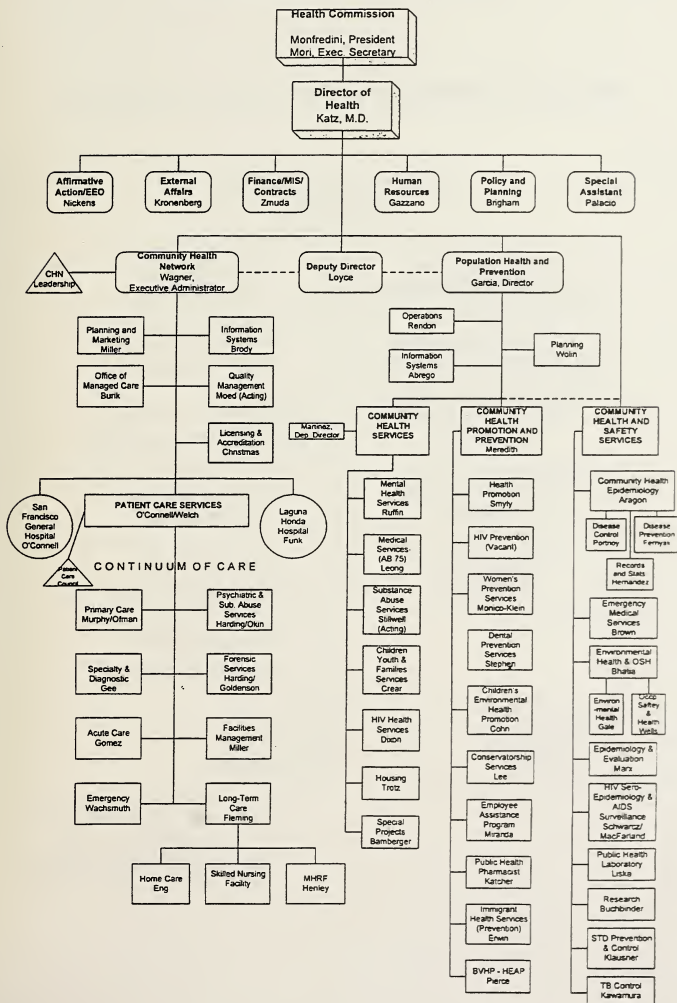
### **B.3 Staff Duties**

Areas of responsibility for all program staff and the MCAH Director are described in the following section. The last part of this section has the current scope of work.

### **B.4 Scope of Work**

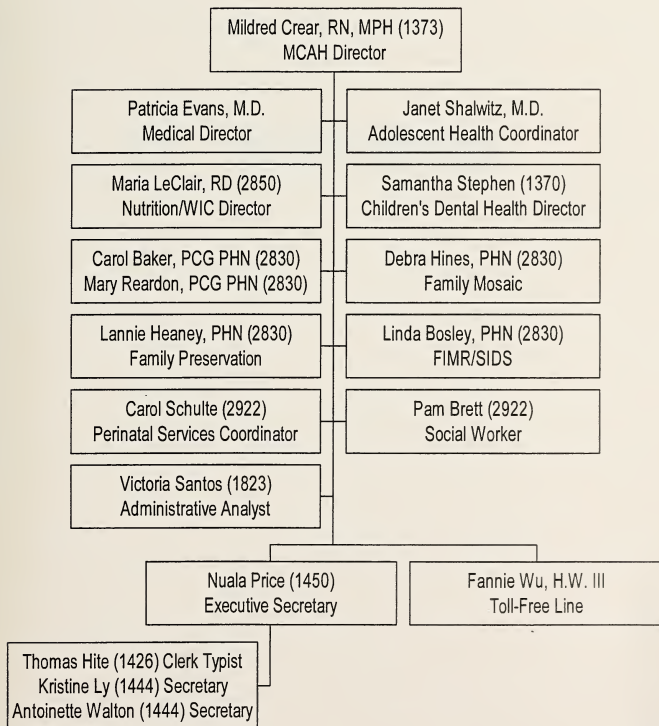


# ORGANIZATIONAL CHART





## MATERNAL CHILD AND ADOLESCENT HEALTH





## **B.3 STAFF DUTIES**



## **1373 Maternal Child Health Director**

### **Duties and Responsibilities**

1. Serves as the principal DPH staff overseeing and directing maternal, child and adolescent health issues and programs.
2. Assess, monitor and report on MCAH population needs and health outcomes through review of relevant data and community needs assessments.
3. Develop programs to meet unmet needs, particularly as they relate to immunizations, school health, high-risk infants, adolescents and mothers.
4. Oversees the implementation of State MCH grant programs and supervises all staff funded through the grant.
5. Represents the DPH locally, regionally and statewide on MCAH issues and collaborates with the state.
6. Actively participates in the development of Medi-Cal managed care and/or health care reform programs related to MCAH populations. Participates in the development of MOUs for compliance related to MCH functions.

**2232 Medical Director  
MCAH Programs**

**Duties and Responsibilities**

1. Provide medical technical assistance to county MCAH services and advise on health/medical standards, policies, and protocol activities for the MCAH population. (40%)
  - a. SFGH QA Committee
  - b. CPA QA Work Group
  - c. Linkage Committee/CHN
2. Develop and implement quality assurance program for MCAH population. (40%)
3. Participate in San Francisco citywide Child Death Review Committee and serve on FIMR Review Committee. (5%)
4. Serve as liaison to SFGH, UCSF and other providers for pediatric, family planning, perinatal and related services and projects. (10%)
  - a. CHN Medical Directors' Meeting
  - b. Infectious Disease Committee
  - c. Coordinating Council for Children, Youth and Families
  - d. Family Mosaic Advisory Committee
  - e. Teen Pregnancy Prevention Committee
  - f. HIV Foster Care Committee
  - g. Blue Cross Health Plan
  - h. OB/Family Planning Advisory Group
5. Assist in the preparation of the Child Health Report and other reports, which serve as assessment tools for the MCAH staff. (5%)

## **2850 Nutrition Director/Consultant**

### **Duties and Responsibilities**

1. Organizes and coordinates all nutrition services within the Health Department. (25%)
2. Provides professional, educational and consultative services to improve nutrition in the community. (40%)
3. Reviews nutrition-related protocols, forms and quality assurance audit tools. (15%)
4. Provides professional, educational and consultative services to DPH staff. (15%)
5. Other duties as assigned. (5%)

## **1824 Principal Administrative Analyst MCAH Programs**

### **Duties and Responsibilities**

1. Develops, monitors and manages MCAH and related budgets under the supervision of project directors and the MCAH Director.
2. Acts as liaison to the DPH administration and Finance departments.
3. Reviews project accounting reports, invoices and other documents for accuracy.
4. Serves as liaison to the DHS Contract Management staff in relation to budget preparation and invoicing for MCAH contracts.
5. Analyzes fiscal impact of new trends, regulations and contract language for review by project directors and the MCAH Director.
6. Prepares and monitors federal financial participation staffing patterns and reporting.
7. Prepares and manages purchases and services provision, including the fiscal component of subcontracts and other DPH procurement for project.
8. Assists Projects Managers and the MCAH Director in personnel acquisition and budgeting.
9. Serves as liaison to federal and state auditing staff.

## **1372 Special Assistant Dental Consultant**

1. Plan a program to improve the oral health status of pregnant women and children in San Francisco. (20%)
2. Organize a program to reduce the oral health status disparities among racial/ethnic groups. (20%)
3. Coordinate and collaborate with community dental programs, CHDP and WIC. (10%)
4. Provide consultation and education training on programs to prevent tooth decay, and maintain positive dental health. (20%)
5. Conduct dental needs assessment for San Francisco pregnant women, children and adolescents. (10%)
6. Provide data on dental health for women, children and adolescents. (10%)
7. Serve as dental consultant to MCAH staff and represent MCAH in community meetings regarding dental health. (5%)
8. Attend MCAH meetings as needed. (5%)

## **2922 Senior Medical Social Worker Perinatal Services Coordinator**

### **Duties**

1. Provide technical assistance such as interpretation of CPSP and Medi-Cal regulations, quality assurance activities, program and analysis, billing reviews, provider trainings, and related matters for approved CPSP providers. (75%)
2. Review CPSP application changes in collaboration with the Perinatal Services Consultants, analyze application materials in relation to program regulations and make recommendations to Maternal and Child Health. (5%)
3. Plan, organize and facilitate the CPSP Roundtable made up of all approved CPSP providers and DPH staff. (5%)
4. Identify and recruit new private OBs or clinic-based CPSP providers by providing information and technical assistance to potential providers concerning the CPSP application process and program. (2%)
5. Review CPSP applications in collaboration with other staff consultants, analyze Medi-Cal managed care application materials in relation to program regulations, assess whether applicant has adequate and appropriate resources for program and make recommendations to maternal Child Health. (1%)
6. Collaborate with DPH programs such as MCH referral Line, WIC, CHDP, Perinatal Guidance Program, and DSS in relation to perinatal services. (1%)
7. Attend regional CPSP Coordinators' meetings and serve as liaison to DPH Perinatal Services and local CPSP providers. Attend Bay Area CPSP coordinators' meetings (Bay Area Perinatal Advocates). (2%)
8. Maintain and update a list of approved CPSP providers and distribute to appropriate agency representatives as needed. (1%)
9. Participate in Perinatal Services staff meetings, DPH task forces, Children, Youth and Family Services' meetings, work groups, and represent SFDPH at community and other meetings. (1%)
10. Participate in and staff San Francisco Perinatal Forum (a consortium of private, community and public perinatal providers working with the DPH) subcommittees or task forces. (3%)
11. Attend local, regional and State meetings, trainings and conferences as needed. (1%)
12. Produce reports and other documents as requested. (1%)
13. Other related duties as assigned by the MCAH Director. (1%)

## **2830 MCAH Public Health Nurse**

### **Duties and Responsibilities**

1. Serves as the PCG Coordinator. (20%)
2. Interview pregnant women who are applying for AFDC/Medi-Cal and assist them to get appropriate medical supervision and community resources. (20%)
3. Provide information about pediatric care and the importance of comprehensive periodic care from the time of the child's birth. (10%)
4. Make Public Health Nursing referrals as needed. (5%)
5. Serve as a liaison to eligibility workers in AFDC and provide professional consultation regarding the health conditions of their clients. (10%)
6. Attend meetings of the Perinatal Forum, Prenatal Substance Abuse Coordinating Council and the Mayor's Office of Children, Youth and Families. (10%)
7. Collaborate with community health workers from the Black Infant Health Project and the Homeless Prenatal Program. (5%)
8. Collaborate with DHS GAINS program workers and serve on CalWorks committee. (10%)
9. Prepare quarterly and other reports. (5%).
10. Attend MCAH meetings as requested. (5%)

## **2830 MCAH Public Health Nurse**

### **Duties and Responsibilities**

1. Review medical charts of pregnant women and make appropriate referrals for community services. (25%)
2. Provide information about pediatric care and the importance of comprehensive periodic care from the time of the child's birth. (10%)
3. Make Public Health Nursing referrals on all deliveries at county hospital. (10%)
4. Serve as a liaison to hospital social workers and medical staff. Provide professional consultation. (10%)
5. Participate in case conferences to review clients' needs. (10%)
6. Interpret CPSP protocols and guidelines to social workers and physicians at county hospital. (10%)
7. Collaborate with community based programs regarding the needs of the perinatal population. (10%)
8. Participate in medical staff training about MCAH programs. (5%)
9. Attend MCAH meetings as requested. (5%)
10. Prepares monthly reports on activities. (5%)

## **2830 Public Health Nurse Family Mosaic Project**

### **Duties**

1. Review Health Assessments after completion by Family Advocate/Worker to identify unmet health needs of adolescents and children. (30%)
2. Consult with Family Advocates/Workers regarding health related problems or health maintenance needs of FMP clients and family members. (20%)
3. Make PHN referrals for Family Advocate/Worker to assess health needs. (5%)
4. Make referrals to appropriate health agencies for follow-up of medical needs. (5%)
5. Review medical records obtained by Family Advocate/Worker from hospital and private MDs to clarify medical needs. Help interpret medical reports to FMP staff. (15%)
6. Assist in making medical appointments at San Francisco General Hospital, other hospital clinics and/or private medical practitioners. (2%)
7. Consult with and give support to FMP Parent Support Group for health education to group members. (2%)
8. Participate in collaborative meetings. (5%)
9. Cultivate and solicit community health providers and private practitioners to offer services for FMP clients and families. (5%)
10. Participate in planning for health training sessions. (5%)
11. Serve as liaison between Mental Health and MCAH. (1%)
12. Attend local and State MCH meetings. (5%)

**2830 MCAH Public Health Nurse**  
**(Family Preservation)**

**Duties**

1. Serve as liaison with Department of Health Services Family Preservation unit and provide professional consultation regarding health needs of women and children. (30%)
2. Participate in planning meetings to develop programs regarding health services for families in family reunification, adoptions and family preservation. (25%)
3. Represent MCAH in community forums regarding family preservation. (20%)
4. Provide consultation to social workers in the Family Preservation unit. Participate in training of staff regarding health issues. (10%)
5. Make public health nursing referrals as needed. (5%)
6. Prepare reports on findings of the program, interaction and outcomes. (5%)
7. Attend MCAH meetings as requested. (5%)

**2830 Public Health Nurse  
FIMR/SIDS**

**Duties**

1. Conduct parental interviews and family members who have experienced the loss of a fetus or infant. (20%)
2. Make PHN referrals for parental interviews on cases which coordinator does not visit. (5%)
3. Review and abstract information from hospital medical records. (30%)
4. Receive all birth/death certificates and assign FIMR ID numbers. (2%)
5. Confer with PHNs regarding SIDS cases. (5%)
6. Participate on County Child Death Review Committee. (10%)
7. Convene FIMR technical review team and prepare material for review. (10%)
8. Prepares county data base and State reports. (5%)
9. Participate in County and State mid-year FIMR and quarterly SIDS meetings. (5%)
10. Collaborate with medical providers and community agencies. (5%)
11. Participate in planning for trainings related to SIDS and child abuse. (3%)

## **2830 MCAH Public Health Nurse (Special Needs Programs)**

### **Duties**

1. Serve as a liaison to a Special Children's Unit at the Department of Human Services. (30%)
2. Provide professional consultation to social workers in the unit. Participate in training of staff regarding health care. (25%)
3. Participate in planning for health care needs of the Special Children's population. (20%)
4. Represent MCAH in community/provider meetings regarding Special Children population. (10%)
5. Make public health nursing referrals as needed. (5%)
6. Document services provided to workers on behalf of children with special needs that can be used in MCAH planning. (5%)
7. Attend MCAH meetings as requested. (5%)

## 2822 Health Educator

### Duties and Responsibilities

1. Develop or review and revise health education protocols, assessment tools and care plans annually. Sign off on DPH and Perinatal Forum clinic protocols. (25%)
2. Develop and implement in-service trainings, programs and workshops for Perinatal Forum, CPSP providers and others. (20%)
3. Coordinate projects, make presentations and prepare proposals, budgets and reports as assigned. Oversee outreach activities and conduct community health promotion activities. (15%)
4. Supervise one assistant health educator in perinatal health education duties. (10%)
5. Participate in and staff Perinatal Forum committees, Children, Youth and Family Services committees, and DPH work groups as assigned. (10%)
6. Review or develop perinatal health education materials. Distribute new health education materials to DPH and other perinatal sites. (10%)
7. Consult with perinatal health education staff at Perinatal Forum sites and provide technical assistance. (5%)
8. Participate in Perinatal Services quality assurance activities. Ensure that protocols and standards for health education services are in conformance with Federal, State and local regulations. (5%)

**2922 Senior Medical Social Worker  
MCAH Social Work Consultant  
Duties and Responsibilities**

1. Provide technical assistance and training in implementation of psychosocial services for maternal, child, and adolescent programs and related MCAH projects and programs. (30%)
2. Provide staff support and participate in Perinatal Substance Abuse committee. (5%)
3. Participate in Perinatal Services quality assurance activities. Develop, review and revise perinatal psychosocial protocols as needed. Sign off on DPH and Perinatal Forum clinic protocols in conformance with federal, State and local regulations. (20%)
4. Gather and disseminate information on resources, research, training, and materials relevant to perinatal social work providers and others. (10%)
5. Coordinate Perinatal Social Workers Committee. (2%)
6. Coordinate and participate in planning for the Homeless Perinatal Regional Group. (15%)
7. Coordinate and provide supervision for the MCH toll-free line. (10%)
8. Participate in developing training programs for MCH related activities i.e. child abuse and domestic violence. (5%)
9. Prepare reports as needed related to activities performed. (3%)

## **2587 Bilingual Health Worker III Toll-Free Line**

### **Duties**

1. Answers MCH toll-free line, triages and assesses health care needs of callers, and provides appropriate family planning, perinatal, WIC, or child health referrals.
2. Refers women callers to breast and cervical cancer screening providers or other toll-free information and education lines.
3. Maintains the toll-free directory of services and other related resource directories by contacting sites and providers as well as compiling up-to-date information for use by the toll-free workers and perinatal services.
4. Prepares, collects and reports data on use of the toll-free services line.
5. Conducts outreach to the community through participation in health fairs and other events, and "inreach" to DPH and other providers to promote use of the MCH toll-free line.
6. Translate related materials as requested.

## **1450 Executive Secretary**

### **Duties**

1. Compose and type routine correspondence requiring general knowledge of DPH and project activities.
2. Serve as staff to Perinatal Forum and MCAH Advisory Board meetings: attend and take minutes, prepare agendas, schedule meetings, prepare mailings, and maintain updated mailing and membership lists.
3. Complete monthly contractor invoices for Perinatal Services.
4. Prepare daily time sheets; liaison with Payroll Department; maintain personnel records regarding leave.
5. Type grant proposals as required.
6. Maintain calendar for MCH Director.
7. Update and maintain office manual of procedures for use in department.
8. Oversee office space arrangements, telephone service, office equipment and other related office services.
9. Supervise clerical staff.
10. Perform other related duties as assigned by MCH Director.

## 1426 Clerk Typist

### Duties

1. Maintain confidential data and other program files for FIMR and PM 357s.
2. Type correspondence, forms and reports for FIMR and PM 357s for welfare case data system.
3. Enter data into the FIMR and SFDATA database.
4. Enter data for PM 357s welfare case data system weekly.
5. Prepare quarterly mailing of disk and hard copy of FIMR reports for State MCH.
6. Prepare monthly MUNI purchase order.
7. Word process routine correspondence.
8. Track and order routine office supplies
9. Serve as receptionist and answer and route telephone calls. Shared responsibility with other secretaries.
10. Other duties as assigned.

## **1444 Secretary 1**

### **Duties**

1. Wordprocess routine correspondence, newsletters, and reports as requested.
2. Word process protocol updates and revisions.
3. Serve as receptionist and answer and route telephone calls. Shared responsibility with other secretaries.
4. Assist with conference and training arrangements as requested.
5. Type reproduction requests, direct payment vouchers, and travel requisitions.
6. Prepare and type purchase orders as needed.
7. Other duties as assigned.

## **Job Description**

### **1444 Secretary 1**

1. Word process routine correspondence and reports.
2. Enter data into adolescent health database.
3. Maintain adolescent health mailing list.
4. Schedule and prepare agendas and minutes for adolescent health meetings.
5. Maintain Medical Director's calendar.
6. Answer and route phone calls.
7. Track and order routine office supplies.
8. Other duties as assigned.

**1444 Secretary  
Ear Center (4 Hours)**

**Duties**

1. Order forms and supplies as needed.
2. Maintain and update correspondence to schools and patients
3. Assist in the follow-up of failed case – parochial and CHDP
4. Maintain filing system
5. Answer phone calls and route to appropriate area
6. Make appointments
7. Assist in developing computer data base
8. Data entry
9. Assist with delivery of CHDP forms and completion of CHDP forms

### **9924 Public Health Aide (Intern)**

#### Potential Activities:

1. Assist with specific workshops through planning with task force members and DPH staff in preparing flyers, organizing and implementing events, i.e., Adolescent Health BIH, Prenatal Homeless.
2. Assist in the preparation of annual development reports or other relevant data: Adolescent, Child Health.
3. Assist with work groups or task force meetings by preparing meeting notices, agendas, taking minutes and presenting updates.
4. Assist in evaluation or data collection implementation activities.
5. Conduct resource surveys and other activities related to assessment and improvement of women's, children's and adolescent health.
6. Assist in trainings related to perinatal, adolescent and children's issues.
7. Similar duties related to MCH projects as assigned.

**9924 Public Service Aide  
(Research Assistant)**

Potential Activities:

1. Conduct, analyze and write up research focusing on improving the health and well-being of children and youth in San Francisco.
2. Establish policies and procedures pertaining to child and adolescent health.
3. Coordinate meeting and trainings.
4. Write letters, minutes and reports.
5. Other duties as assigned.

## **B.4 SCOPE OF WORK**



## **MATERNAL AND CHILD HEALTH (MCH) SCOPE OF WORK**

The Agency must work toward achieving the following goals and accomplish the following objectives. This will be done by performing the specified activities and evaluating the results using the listed methods focusing on process and/or outcome.

**Goal 1: All children born healthy to healthy mothers.**

**Goal 2: No health status disparities among racial/ethnic, gender, economic and regional groups.**

**Goal 3: A safe and healthy environment for women, children and their families.**

**Goal 4: Equal access for all women, children and their families to appropriate and needed care within an integrated and seamless system.**

Timelines: All of the implementation activities identified in this Scope of Work are to be conducted within the term of this allocation's Fiscal year.

### **Objective 1**

**The Agency will operate an MCH Program under the direction of an approved MCH Director in accordance with the State MCH Branch Policies and Procedures.**

### **Implementation Activities**

1.1 The Agency, under the direction of the MCH Director, will:

- develop policies and standards, and conduct activities that improve health outcomes for the MCH population;
- develop Agency and/or community infrastructures that provide family-centered, culturally-competent services;
- use core public health functions to assure that progress is made toward the four MCH goals and thirteen objectives.

### **Evaluation Process or Outcomes-**

The MCH Director will meet professional qualifications and time commitment specified in the MCH Policies and Procedures and submit verification of requirement compliance to the MCH Branch for approval. Activities performed under this objective shall be documented in writing as part of the Annual Report.

1.2 The MCH Director will have the responsibility for implementation of MCH programs including (where applicable):

- Adolescent Family Life Program
- Black Infant Health Program
- Comprehensive Perinatal Services Program
- Fetal/Infant Mortality Review Program
- Perinatal Outreach and Education

#### Evaluation Process or Outcomes-

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

#### **Objective 2**

**Under the direction of the MCH Director, the Agency must provide a coordinated local effort to improve outreach and case finding activities for pregnant women and children including care coordination activities stressing early and continuous perinatal infant, and child care.**

#### **Implementation Activities**

2.1 The Agency should perform comprehensive outreach activities to the MCH population, including referrals to the Healthy Families Program.

2.1.a The Agency must maintain and promote the availability of the following:

- Title V toll-free telephone information service
- Perinatal Outreach and Education Program
- Prenatal Care Guidance
- Other coordinated outreach and case finding efforts

#### Evaluation Process or Outcomes-

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

#### **Objective 3**

**The Agency must provide skilled professional expertise, appropriate to the population needs of the jurisdiction, in identifying, coordinating, and expanding health and human services for pregnant women and children through collaborative planning, development, and assurance of quality perinatal services.**

#### **Implementation Activities**

3.1 The Agency must have an approved Perinatal Services Coordinator who meets the professional qualifications and time commitment specified in the MCH Policies and Procedures.

#### Evaluation Process or Outcomes-

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

3.2 Perinatal Services Coordinators must carry out the responsibilities and activities detailed in the MCH Policies and Procedures.

#### Evaluation Process or Outcomes-

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

#### **Objective 4**

**Address priority unmet needs identified in the local Community Health Assessment and MCH Plan; continue to monitor MCH needs and make modifications to the local Plan in order to achieve the desired outcome of improved maternal, child, and adolescent health**

#### **Implementation Activities**

4.1 To improve adolescent health and assure accessible, high quality, culturally competent, and coordinated adolescent health services, the following activities will continue:

- a. Increase awareness of adolescent services provided by the San Francisco Department of Public Health (SFDPH)
- b. Educate SFDPH staff, San Francisco service providers, and San Francisco youth and families regarding the health status of San Francisco adolescents.
- c. Improve SFDPH's ability to provide youth-appropriate services.
- d. Encourage youth involvement in SFDPH activities.

#### **Evaluation Process or Outcomes:**

1. Maintain on file: members of the Adolescent Health Working Group; policy position papers; revised histories and screening tools and clinic protocols.
2. In the Mid-Year and Annual Reports summarize the impact of the Adolescent Health Working Group policies and clinic protocols on DPH/CHN clinics and other community agencies as relevant. As data become available, impacts on adolescents' access to care and use of health services, satisfaction with health services or changes in health behavior may be reported.

4.2 To assure that women, children and youth will have access to appropriate oral health and dental prevention and treatment services and education, the following activities will continue:

- a. Promote the dissemination of protocols and procedures for oral health among MCAH and dental care providers.
- b. In collaboration with DPH and other providers, review existing data, community needs assessments and identifies gaps, service needs and barriers to care and education.
- c. Work toward minimizing barriers to care and education through the development of screening and treatment referral sources, promoting prevention services and establishing a prevention program within DPH and the broader community.

#### **Evaluation Process or Outcomes:**

1. Maintain on file: assessment protocols, procedures for oral health screening and referral.
2. In the Mid-Year and Annual Reports summarize progress in developing dental screening and treatment referrals. As data become available, impacts on access to dental care and use of dental services, satisfaction with dental services or changes dental health behavior may be reported.

Agency:

Allocation Number:

## **PERINATAL OUTREACH AND EDUCATION (POE) SCOPE OF WORK**

The Agency must work toward achieving the following goals and accomplish the following objectives. This will be done by performing the specified activities and evaluating the results using the listed methods focusing on process and/or outcome.

**Goal 1: Coordinate and provide outreach and case-finding to women of childbearing age exposed to tobacco.**

Timelines: All of the implementation activities identified in this Scope of Work are to be conducted within the term of this allocation's Fiscal year.

### **Objective 1**

Maintain an established, coordinated and integrated outreach system for low income, high risk women of childbearing age. The system will increase access to care and client advocacy through; outreach activities, referrals and health education, including tobacco cessation and substance abuse prevention.

### **Implementation Activities**

- 1.1 Continue to identify and define at risk target populations based on local perinatal data and statistics, and develop strategies for outreach to the identified target population.
- 1.2 Review all local outreach efforts, by; contact with clinics, schools, agencies, managed care plan contractors serving women of childbearing age, adolescents, and pregnant/parenting women.
- 1.3 Identify and address barriers and unmet needs in the provision of services for pregnant/parenting women.
- 1.4 Develop, implement and update outreach program protocols, procedures, instructional materials, in service training, and data collection formats where applicable, for the provision of tobacco and substance abuse prevention education to adolescents, pregnant and parenting women.
- 1.5 Develop and/or update a list of community resources for women of childbearing age, including tobacco cessation and other substance abuse resources.
- 1.6 Coordinate and collaborate with other MCH programs, community agencies, as well as providers serving pregnant and parenting women to:
  - Coordinate planning of outreach to at-risk women;
  - Provide health screening and information to perinatal health services; and
  - Provide culturally and linguistically appropriate services to discourage the use of tobacco and other drugs.

### Evaluation Process or Outcomes-

1.1-1.6

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

Submit an updated Annual Report, as outlined in the MCH FY 1999-2000 Policies & Procedures.

**Objective 2**

Provide case finding and/or care coordination activities to targeted at-risk women. Programs should stress early and continuous prenatal care. In addition, assessment of substance use and case referral to smoking cessation and/or substance abuse prevention resources should be included, as necessary.

**Implementation Activities**

- 2.1 Work with community resources and health care providers to furnish: skilled professional assessment, case finding, care coordination, education, support and referral that increases access to care.
- 2.2 Integrate and coordinate client advocacy and health education services into each local Agency program. Include BIH and other MCH programs providing outreach services.
- 2.3 Develop and implement an individualized strategy to prevent smoking and exposure to smoke during pregnancy and the postpartum period:
  - Include counseling and advocacy services, public health nursing services, provision of motivational messages, non-monetary incentives, such as child care, transportation and translation services;
  - Provide tobacco cessation or other substance use prevention activities in conjunction with those activities; and
  - Provide follow-up, reassessment, maintenance, and relapse prevention.
- 2.4 Advocate for maternal and child health programs by participating in community, professional, and interagency meetings. Provide expertise on perinatal health issues.

Evaluation Process or Outcomes-

2.1-2.4

Documentation of activities, under Objective 2, and educational materials will be kept in Agency files and reported in the Mid-Year and Annual and reports.

Records will be kept in the Agency files, and reported in Mid-Year and Annual and reports.

### **Objective 3**

Evaluate outreach activities as they relate to the State's MCH priorities and the Agency Health Assessment and Multi-Year Plan.

#### **Implementation Activities**

- 3.1 Develop proposed measures of success for outreach activities, including methods to avoid duplication of services with other programs outreaching to the same target population (i.e. PCG, BIH, AFLP, etc):
  - Rationale for selection of targeted women; and
  - Description of activities to increase access to care.
- 3.2 Record the total number of clients reached by this program and, where possible, categorize the numbers by the following characteristics:
  - Race/ethnicity;
  - Adolescent/non-adolescent;
  - Pregnancy status;
  - Substance abuse (smoking, alcohol, drugs); and
  - Probable payment source.
- 3.3 Record the number of non-pregnant/pregnant women referred to smoking cessation and/or alcohol/drug treatment and, of these, the number/percent of those enrolled in treatment, and number/percent who completed treatment.

#### Evaluation Process or Outcomes-

Maintain documentation of activities on file. Summarize activities and describe outcomes/impact in the Mid-Year and Annual Reports in accordance with FY 99/2000 Policies and Procedures.

- 3.1 In the Mid-Year Report submit a summary and discussion of the impact of the program in the jurisdiction related to the following:
  - Increasing the proportion of targeted women who receive prenatal care in the first trimester;
  - Reducing the rate of low birth weight;
  - Reducing the rate of substance abuse (smoking, alcohol, and drugs).
- 3.2 In the Annual report, submit items and Progress Report Forms provided, as outlined in the MCH FY 1999-2000 Policies and Procedures. Include methods of collaboration and coordination utilized to avoid duplication of outreach and health education services.

Agency:

Allocation Number:

## **BLACK INFANT HEALTH PROGRAM (BIH) SCOPE OF WORK**

The Agency must work toward achieving the following goals and accomplish the following objectives. This will be done by performing the specified activities and evaluating the results using the listed methods focusing on process and/or outcome.

- Goal 1:** To reduce African-American infant mortality through a comprehensive community-based effort by assuring that at-risk pregnant and parenting women and their infants and children up to age two have access to quality maternal and child health services.
- Goal 2:** To reduce the number of African-American infants born with birthweights below 2,500 grams.
- Goal 3:** Reduce the number of African-American women who smoke, use alcohol, and/or nonprescription drugs during pregnancy.
- Goal 4:** Reduce the number of African-American babies who die due to SIDS.

Timelines: All of the implementation activities identified in this Scope of Work are to be conducted within the term of this allocation's Fiscal year.

### **Objective 1**

Conduct a community-based BIH Program in the local jurisdiction that supports, facilitates, and promotes better health care services for at-risk African-American women, children up to age of two years, and their families.

### **Implementation Activities**

- 1.1 Maintain a culturally-competent Coordinator to oversee and administer the program and carry out the responsibilities and activities detailed in the MCH Policies and Procedures.
- 1.2 Provide and/or assuring culturally-competent outreach in the African-American community targeting pregnant and parenting women at risk for poor birth outcomes. (Identify zip codes for outreach concentration) Outreach should follow the outreach intervention model made available by the MCH Branch.
- 1.3 Provide and/or assuring access to appropriate perinatal services and continuous care coordination including follow-up services to assure timely acquisition of postpartum, well-baby care and immunizations, and other essential services for the well being of infants, children from birth through 24 months, and their mother.

### **Evaluation Process or Outcomes-**

- 1.1-1.3 In the Mid-Year Progress and Annual Reports, describe key activities and accomplishments toward implementing and maintaining the core elements and specific BIH Program Coordinator responsibilities.
- 1.4 Identify by intervention the number ( ) of African-American clients proposed to serve through the BIH intervention(s) during FY 1999/00.

Evaluation Process or Outcomes-

- 1.4 Summarize clients served in the Mid-Year Progress Report including more details in the Annual Report.
- 1.5 Identify/add additional local objectives and activities aimed at achieving the goals of the BIH Program, (such objectives and activities must clearly expand and amplify community-based efforts aimed at improving the health and well being of African-American women, infants, children, and their families.

Evaluation Process or Outcomes-

- 1.5 Document key activities and accomplishments toward implementing local objectives and activities in the Mid-Year Progress and Annual Reports
- 1.6 Coordinate and collaborate with all relevant service programs and with community groups to increase the availability and accessibility of appropriate services and to improve community awareness regarding problems associated with infant mortality in the African-American community.
- 1.7 Utilization of the BIH Data Collection System (MIS) each month to ensure that BIH data is input, updated, and maintained for monthly electronic uploading to the MCH Branch

Evaluation Process or Outcomes-

- 1.7 Each BIH health jurisdiction must maintain local data files to be uploaded to the MCH Branch on a monthly basis. Files will be uploaded no later than the tenth day of the following month.

**Objective 2** Develop and implement educational strategies that assist pregnant African-American women to understand the causes of low birthweight.

**Implementation Activities**

- 2.1 Educate pregnant African-American women on the causes of low birthweight including smoking, substance abuse, and prematurity. Existing educational resources, "What African-American Women Should Know About Preterm Labor" and "How Will I Know If I'm In Preterm Labor", as well as other appropriate materials may be use as guides to prevent premature births.
- 2.2 Coordinate with local providers and request during prenatal visit that they educate and provide resource material to pregnant African-American women on the need for adequate prenatal care, healthy lifestyle choices, with emphasis on the need to recognize signs and symptoms of pre-term labor to prevent premature births.

Evaluation Process or Outcomes-

- 2.1-2.2 In the Mid-Year Progress and Annual Reports describe activities toward educating African-American women to understand causes of low birthweight including recognizing signs and symptoms of pre-term labor.

**Objective 3** Coordinate with existing treatment services for substance and alcohol abuse and smoking cessation programs for referral of pregnant African-American women to reduce/eliminate risky behaviors during pregnancy.

**Implementation Activities**

- 3.1 Identify African-American pregnant women who currently use alcohol, illicit substances, and/or tobacco products for referral to appropriate treatment programs.

Evaluation Process or Outcomes-

- 3.1 In the Mid-Year Progress and Annual Reports, describe activities toward working with clients to reduce/eliminate adverse behavior (substance/alcohol use and smoking) during pregnancy.
- 3.2 Monitor client's behavior modification to identify a reduction in adverse behavior during pregnancy.

Evaluation Process or Outcomes-

- 3.2 In the Mid-Year Progress and Annual Reports document the number of women referred to treatment programs and any successes with women modifying adverse behavior.

**Objective 4**

In conjunction with the State's SIDS Program, educate African-American families on SIDS deaths in the African-American community and strategies that may prevent SIDS deaths.

**Implementation Activities**

- 4.1 Disseminate and discuss SIDS resource materials including the Back to Sleep campaign to pregnant African-American families.

Evaluation Process or Outcomes-

- 4.1 In the Mid-Year Progress and Annual Reports, describe activities conducted to teach African-American pregnant families about SIDS and how SIDS deaths may be prevented.
- 4.2 Assess and monitor new born sleeping patterns with mothers during follow-up visits.

Evaluation Process or Outcomes-

- 4.2 In the Mid-Year Progress and Annual Reports, describe the number of women/men and their families who received information on the Back to Sleep campaign.

Agency:

Allocation Number:

## FETAL INFANT MORTALITY REVIEW (FIMR) SCOPE OF WORK

The Agency must work toward achieving the following goals and accomplish the following objectives. This will be done by performing the specified activities and evaluating the results using the listed methods focusing on process and/or outcome.

- Goal 1: Examine local contributing factors to fetal, neonatal, and postneonatal deaths, and develop and implement interventions responding to identified needs.**

Timelines: All of the implementation activities identified in this Scope of Work are to be conducted within the term of this allocation's Fiscal year.

### **Objective 1**

Conduct a community-based FIMR Program based on MCH Branch guidelines to: 1) examine contributing factors to fetal, neonatal, and postneonatal deaths; 2) develop recommendations to respond to identified needs; and 3) implement one interventions involving policy, systems, and community norm changes that will lead to the prevention of similar occurrences. (The number of interventions implemented is subject to MCH Branch approval.)

### **Implementation Activities**

- 1.1 Obtain current and ongoing local approval to conduct the FIMR program reviews.

#### Evaluation Process or Outcomes-

- 1.1 Submit local Health Officer authority letter with Annual Progress Report.
- 1.2 Develop policies and procedures, establish, facilitate, and maintain a case review and community action team, to review selected cases, identify factors contributing to fetal and infant deaths and recommend and implement changes that are designed to prevent further occurrence.

#### Evaluation Process or Outcomes-

- 1.2 Submit policies and procedures of case review and community action teams with Annual Progress Report. Refer to the MCH Policies and Procedures for a description of key activities and accomplishments towards maintaining the case review and community action teams; summarize accomplishments in the Mid-Year and Annual Progress Reports.
- 1.3 Complete the data collection; parental interview, when possible; review process; and analysis on up to 75 appropriate cases identifying medical and non-medical factors. (Case number must be appropriately proportional to the total number of fetal/infant deaths and is subject to MCH Branch approval.)

#### Evaluation Process or Outcomes-

- 1.3 Complete a "Case Review Summary Form" for each case reviewed and input the data into the *EpiFIMR* software program.

Analyze data and generate *EpiFIMR* reports; submit findings and database reports with Mid-Year and Annual Progress Reports.

- 1.4 Develop summary report of findings and recommendations that address the identified contributing factors leading to fetal/infant deaths; disseminate findings to community action team, local policymakers, the community at large, BIH, SIDS, and other local MCH programs through published reports, press releases, and presentations to increase public awareness of recurring factors causing fetal/infant deaths.

Evaluation Process or Outcomes-

- 1.4 In the Mid-Year and Annual Progress Reports, describe key activities and accomplishments. Submit the summary report with the Annual Progress Report. Documentation of disseminated findings to be kept on file.
- 1.5 Based on case findings, with community input, develop and implement objectives, interventions, timelines and evaluation components for identified recommendations which address systems, community norm and public policy changes.

Evaluation Process or Outcomes-

- 1.5 In the Mid-Year and Annual Progress Reports, describe key activities and accomplishments. Submit the objectives, interventions and evaluation plan for the identified recommendations with the Annual Progress Report. Describe how community input was obtained and incorporated.



## **C. COMMUNITY AND HEALTH SYSTEMS**

### **C.1 Relationship of Local MCH Program with Relevant Public Health and Community Organizations**

San Francisco has a plethora of groups planning programs/services for children, youth and pregnant women. The challenge is to have a coordinated collaborative endeavor.

Children, Youth and Family Services staff serve on many planning bodies representing Maternal and Child Health. The MCAH Program also staff several planning groups:

- Children's Coordinating Council
- Perinatal Forum
- Black Infant Health Task Force
- Perinatal Substance Abuse Council
- FIMR Task Force

A brief description of the major planning groups follows.

### **C.2 Service and Health Providers for Children and Childbearing Women.**

### **C.3 Program Funders for Children and Youth**



# CHILDREN, YOUTH AND FAMILY SERVICES

## Standing Meetings

Meeting	Attendee(s)	Frequency	Time	Location
Adolescent Health Working Group	Janet Shalwitz	Monthly	Varies	Varies
Adolescent Health Subcommittee of the CCCYF	Janet Shalwitz	1 <sup>st</sup> Thursday of month	10:30 – 12:30	Varies
Adolescent Services Group	Janet Shalwitz Pat Grandberry Cassandra Perkins	Monthly	Varies	Varies
Adolescent Wellness (CA)	Janet Shalwitz	Monthly	All Day	Sacramento
American Diabetes Association	Maria LeClair	Monthly – varies	5:30 – 8:00 p.m.	SFGH
Asthma Task Force	Mildred Crear	Third Friday of month	10 – 12 a.m.	Southeast H.C.
Bay Area Deputy Directors	Twila Brown	2nd Thurs. of month	All day	Berkeley
BAPA	Carol Schulte	Monthly	Varies	Varies
Bayview Environmental Task Force	Pat Evans	4th Thurs. of month	5:30 to 7:00 p.m.	Southeast Health Center
BIH Task Force	Gail Ervine Tracy Moore	Quarterly	1:30 – 3:30 p.m.	Varies
Bridging the Gap	Pam Brett	1 <sup>st</sup> Wed. of month	3:30 – 5:00 p.m.	1380 Howard
Bringing Up Healthy Kids Coalition	Carol Schulte Janet Shalwitz	Varies	Varies	Varies
CA Healthy Families QI	Janet Shalwitz	Monthly	Varies	Varies
CalWorks Service	Pam Brett Mildred Crear Mary Reardon Janet Shalwitz	1 <sup>st</sup> & 3 <sup>rd</sup> Thurs of month	1:00 – 3:00 p.m.	1380 Howard
CCS Administrators	Twila Brown Rita Times	Monthly	Varies	Varies
CHDP Bay Area Deputy Directors Dental Subcommittee	Samantha Stephen	Quarterly	Monday, 9:30 – 1:30	Berkeley
CHDP State Dental Subcommittee	Samantha Stephen	Quarterly	Varies	Sacramento
CHIN Ethics Committee	Janet Shalwitz	3 <sup>rd</sup> Monday of Month	Noon – 1:30 p.m.	SFGH
CHIN Linkage Committee	Carol Schulte	4 <sup>th</sup> Wednesday of Month	8:00 – 9:30 a.m.	SFGH

Meeting	Attendee(s)	Frequency	Time	Location
CHN QI	Pat Evans Liz Rojas	3 <sup>rd</sup> Monday of month	8:00 – 10:00 a.m.	Ocean Park H.C.
Coordinating Council for CYF	Twila Brown Mildred Crear Janet Shalwitz Pat Evans Maria LeClair Samantha Stephen	1 <sup>st</sup> Thursday of month	8:30 – 10:30 a.m.	Varies
CPC Medical Directors	Pat Evans	2nd & 4th Fri. of month	8:00 to 10:30 a.m.	Maxine Hall H.C.
CPC Medical Staff	Pat Evans	Quarterly	Varies	Silver Avenue H.C.
CPC QA	Pat Evans	Monthly	8:15 – 9:45 a.m.	Ocean Park H.C.
CPC Peer Review Subcommittee	Pat Evans	Monthly	Varies	Varies
CTPRN Prevention	Liz Rojas	Quarterly	10:00 – 12:00	AIDS office
CYF Senior Staff Meeting	Senior Staff	2 <sup>nd</sup> and 4 <sup>th</sup> Mon. of month	1:00 – 3:00 p.m.	680 - 8th St., Rm. 230
Dental: CHDP local meeting	Samantha Stephen	Monthly	Tuesday a.m.	680 – 8 <sup>th</sup> Street
Dental Prevention	Samantha Stephen	Monthly	Varies	Health Center 3
Dental Clinic Staff Meeting	Samantha Stephen	Monthly	Varies	HC3, HC4, Potrero Hill
Dental: UCSF/PH Seminar Series	Samantha Stephen	Twice monthly	Tues. or Thur. 10-12	700 Parnassus
Dental: CPHA-N	Samantha Stephen	Bimonthly	Tues. or Thur. 12-2	700 Parnassus or Berkeley
Diabetes Coalition of California	Maria LeClair	Every two months	8:30 – 4:00	Sacramento
Domestic Violence Coordinating Council	Mildred Crear	Monthly	Second Wed., 12 – 1:30	SFGH 4J15
East Bay/West Bay Family Planning Providers	Trudi Leong	Every two months	9:30 – 11:00	Berkeley Health Services Bldg.
Family Mosaic Advisory Board	Pat Evans	2 <sup>nd</sup> Monday of month	6:00 p.m.	1309 Evans
Family Planning/HIV Staff Mtg.	Liz Rojas	Monthly	Varies	Varies
Family Planning Providers Group	Trudi Leong	Bimonthly	8:30 to 11:00 a.m.	Berkeley
Family Preservation	Mildred Crear	Quarterly	2 <sup>nd</sup> Wed., 3 – 5 p.m.	Varies
FIMR Case Review	Pat Evans Linda Bosley Pam Brett	1st Monday of month	2:00 – 4:00 p.m.	Maxine Hall Health Center
Forms Committee	Liz Rojas	3 <sup>rd</sup> Monday of month	3:30 – 5:00 p.m.	Silver Avenue H.C.

Meeting	Attendee(s)	Frequency	Time	Location
Health Promotion and Prevention	Samantha Stephen	Twice monthly	Monday, 1:00 – 2:30	101 Grove
High Risk Infant Interagency Council	Pat Grandberry	Monthly	Varies	Varies
HIV Foster Care	Mildred Crear Twila Brown Pat Evans Rita Times	As needed	8:30 to 10:00 a.m.	680 - 8th St., Rm. 200
Injury Prevention Planning Group	Pat Evans	1 <sup>st</sup> Thurs. of month	11:30 – 1:00 p.m.	Varies
March of Dimes Legislative Cmte.	Pam Brett	Quarterly	1 <sup>st</sup> Thurs., 7:30 - 9:30	1050 Sansome St.
MCAH Advisory Board	Mildred Crear Nuala Price	1st Thursday of month	6:00 p.m.- 8:00 p.m.	101 Grove, Rm. 302
Outreach Committee	Liz Rojas Isabel Auerbach Carol Schulte R. Cheney-Cohen	3 <sup>rd</sup> Thursday of month	10:00 – 11:00	680 – 8 <sup>th</sup> Street
Perinatal Forum Ex. Committee	Carol Schulte	Quarterly	Varies	Varies
Perinatal Forum	Pam Brett Isabel Auerbach Carol Schulte Nuala Price	3 <sup>rd</sup> Friday of every other month	8:30 to 10:30 p.m.	Rotates
Perinatal Social Workers	Pam Brett	2/3 times a year	Varies	Varies
PHIP Div. Mgt. Team	Mildred Crear	1 <sup>st</sup> and 3 <sup>rd</sup> Monday	10:30 – 12:00 p.m.	101 Grove, Rm. 220
PH Joint Conference Committee	Mildred Crear	3 <sup>rd</sup> Thurs. of month	10:00 to 12:00 p.m.	101 Grove, Rm. 302
PSACC	Pam Brett	1st Wed. of month	3:30 to 5:00 p.m.	Florence Crittendon
PSACC Steering Committee	Pam Brett	Every other month	4:00 to 5:00 p.m.	Florence Crittendon
Quarterly Lab Meeting	Liz Rojas	Quarterly	1:00 – 3:00 p.m.	101 Grove

Meeting	Attendee(s)	Frequency	Time	Location
School Health Planning Committee	Mildred Crear Twila Brown Pat Evans Janet Shalwitz Samantha Stephen	Quarterly	Varies	101 Grove
SF Child Death Review	Janet Shalwitz Pat Evans Linda Bosley	1st Friday of Month	10:00 a.m. to noon	850 Bryant
SF Breastfeeding Promotion Coalition	Maria LeClair Magdalene Louie T. McCluskey	Quarterly	Varies	Varies
SFDPH Breastfeeding Task Force	Maria LeClair T. McCluskey Carol Schulte	Every 2 months	Varies	Varies
SF Health Plan Advisory Group	Pam Brett	Bimonthly, Day varies	12:30 – 2:30 p.m.	568 Howard Street
SF Immunization Coalition	Tracy Moore T. McCluskey	Monthly	Varies	Varies
SF Family Violence Council Advisory Committee	Mildred Crear Pat Evans	Quarterly	4:00 to 6:00 p.m.	850 Bryant
SF Family Violence Council: Health Committee	Mildred Crear	As needed	9:00 to 10:30 a.m.	
SFGH Peds. Faculty	Pat Evans Janet Shalwitz	1 <sup>st</sup> Wed. of month	12:00 – 1:30 p.m.	SFGH
SIDS No. California Regional Mtg.	Linda Bosley	Every other month	9:30 – 12:30 p.m.	Varies
Starting Points/ECIC	Mildred Crear	3rd Fri. of month	8:30 to 11:00 a.m.	Edgewood Center
System of Care Council	Mildred Crear Janet Shalwitz	4 <sup>th</sup> Thursday of month	3:30 – 5:30	Bay View Plaza
TACC (DHS)	Pam Brett	Quarterly (Wednesday)	10:00 – 12:00	Edgewood Center
Teen Preg. Prevention Planning	Liz Rojas/Pat Evans	Varies	4:00 to 6:00 p.m.	Silver Ave. HC.
WIC Program Outreach Committee	Maria LeClair	Every two months	8:30 – 4:30	Sacramento
WIC Bay Region	M. LeClair/M. Louie Magdalene Louie	Quarterly	8:30 – 3:00 p.m.	San Leandro

## Child Care Planning and Advisory Council

<b>Planning Effort:</b>	In October 1991, Governor Wilson signed Assembly Bill No. 2141, "Partnerships for Child Care." This bill directed all counties to create a local child care planning council that would initiate local child care planning, set priorities for use of block grant funds, and prepare a comprehensive community child care plan in accordance with state guidelines.
<b>Mission/Goals:</b>	The mission of the local child care planning councils is to assess child care priorities, to assist the California Department of Education (CDE) and the Child Development Program Advisory Committee in establishing local priorities for local child care services, and to prepare a comprehensive child care plan.
<b>Membership:</b>	In San Francisco, the Child Care Planning and Advisory Council (CCPAC) is comprised of representatives appointed by Mayor Brown, the Board of Supervisors, Superintendent Rojas and the Board of Education. The membership must include parents, child care providers, and reflects the diversity of the county.
<b>Staffing:</b>	The Mayor's Office of Children, Youth and Their Families' Child Care Coordinator staffs CCPAC. A consultant has also been hired by the Council to assist in staffing needs.
<b>Funding Source:</b>	San Francisco received \$50,000 from the State for FY 1997/98 to be used to support the local child care planning council. The Council also received a planning grant last year from the Miriam and Peter Haas Fund.
<b>Contact:</b>	Deedra Jackson Grant Manager Mayor's Office of Children, Youth, and Their Families 1390 Market Street, Suite 918 San Francisco, CA 94102 phone: 415/554-9329 fax: 415/554-8965

## Children's Coordinating Council

<b>Planning Effort:</b>	<p>The Children's Coordinating Council is policy and planning group of the Department of Public Health (DPH). The council was convened in 1988 to assess the status of health services for San Francisco's children, youth, and their families. The council's work includes:</p> <ul style="list-style-type: none"> <li>• convening ongoing department-wide meetings to develop a unified strategy for children, youth, and families in San Francisco;</li> <li>• advocating on behalf of children, youth, and families;</li> <li>• developing policies regarding child and youth health for DPH executive staff and Health Commission;</li> <li>• communicating program, policy, legislative, and research information to DPH staff and advisory bodies;</li> <li>• reviewing and recommending program, budget, and research priorities to DPH executive staff based on most current health indicators and assessed needs of children, youth, and families; and</li> <li>• establishing and participating in collaborations with other departments, organizations, and individuals to assure children and youth's health needs are identified, assessed, planned for, and evaluated.</li> </ul> <p>The council has five subcommittees: Assessment, Policy, Systems Development, Strategic Planning, and Outreach and Training. The work of the Assessment Committee includes the development of the department's annual report, <i>The Health and Well-Being of Children and Youth in San Francisco</i>.</p>
<b>Mission/Goals:</b>	<p>The mission of the Children's Coordinating Council is to provide strong leadership for policy development, priority-setting, and planning to assure the best possible health and well-being of San Francisco's children, youth, and families.</p>
<b>Membership:</b>	<p>The Children's Coordinating Council is a department-wide planning body at DPH. Membership on the council includes: Community Health Network of San Francisco, Bureau of Children, Youth and Families, Community Health and Epidemiology, Community Substance Abuse Services, Nutrition Services (WIC), STD Program, Dental Program, Balboa Teen Clinic, Silver Avenue Health Center, and San Francisco General Hospital Department of Pediatrics and Family and Community Medicine.</p>
<b>Staffing:</b>	<p>The Children's Coordinating Council is staffed by MCAH and the Planning Department at DPH.</p>
<b>Funding Source:</b>	<p>State General Funds and MCAH funds.</p>
<b>Contact:</b>	<p>Mildred Crear          Director          Department of Public Health - Division of Maternal and Child Health          680 8<sup>th</sup> Street, Suite 200          San Francisco, CA 94110          phone: 415/554-9930 fax: 415/554-9678</p>

## Family Preservation and Support Planning Committee

<b>Planning Effort:</b>	The Family Preservation and Support Planning Committee (FPSPC) convenes focus groups representing the views of different constituencies, such as teen mothers, foster family agencies and relative caregivers. Subcommittees are formed to address administrative and program areas crucial to planning for family support and preservation. Subcommittees are also used to establish collaborative partnerships with ethnic communities in San Francisco. The FPSPC is planning for change within DHS Family and Children's Service operations that is needed in order to realize the vision of a family-focused multidisciplinary approach for child welfare services.
<b>Mission/Goals:</b>	The FPSPC has three broad goals. They are to: <ul style="list-style-type: none"> <li>• Promote the strength and stability of families living in low-income neighborhoods in San Francisco;</li> <li>• Identify opportunities to reform the system of services for families and children; and</li> <li>• Establish continuums of family-focused services that are easily accessed and culturally relevant in neighborhoods that contain large concentrations of African American, Latino or Asian populations.</li> </ul>
<b>Membership:</b>	The membership of the FPSPC is a culturally and ethnically diverse group of more than sixty persons including: parents, foster parents, child and parent advocates, clergy, representatives from community-based organizations, public agencies; and educational institutions.
<b>Staffing:</b>	Department of Human Services
<b>Funding Source:</b>	Funding for the San Francisco Family Preservation and Support Initiative is provided by Federal Family Preservation and Support Funding. In 1995, this five year federal grant provided approximately \$1.2 million to states for family preservation and support programs. Additional funding is provided by the Department of Human Services and the Mayor's Office of Children, Youth and Their Families. The Stuart Foundation has contracted with Philliber Research Associates to evaluate the FSFP Initiative. This is a three-year evaluation grant which began January 1996.
<b>Contact:</b>	Pearl Howell Family Preservation and Support Coordinator Department of Human Services PO Box 7988 San Francisco, CA 94120-7988 phone: 415/557-5364 fax: 415/431-9270

## Foster Care Managed Care Planning Group

<b>Planning Effort:</b>	The Foster Care Managed Care Planning Group began in 1995 to explore issues regarding the transition to managed care for foster care children. There were several concerns regarding the impact of this transition on the ability to provide for the healthcare needs of children in foster care. A county-wide group was formed which looked at the issues created when children are placed out-of-county. From February 1996 through December 1997, this committee met to address the need for procedures and policies which would identify roles and responsibilities of child welfare staff and health care plans in providing for foster children. Initial efforts were directed at maintaining a centralized process for performing health examinations on children prior to placement into foster care. In order to continue this practice, procedures needed to be developed with the health plans in order to ensure reimbursement for San Francisco General Hospital (SFGH).
<b>Mission/Goals:</b>	The goal and outcome of the planning group was to ensure adequate health care provision for children in foster care. Outcomes of the group's work include, agreements to continue the centralized assessment of children at SFGH with reimbursement by health plans for the emergency clearance visits; the development of the procedures necessary to cover the children once placed into foster care; discussions and development of procedures for children on probation; and initial exploratory discussions about placing children in a managed care system, especially medically fragile infants.
<b>Membership:</b>	San Francisco General Hospital, Department of Human Services, San Francisco Health Plan, Blue Cross, and Department of Public Health.
<b>Staffing:</b>	San Francisco General Hospital
<b>Funding Source:</b>	No funding.
<b>Contact:</b>	Ellen Wolfe Pediatric Nurse Practitioner San Francisco General Hospital 1001 Potrero Avenue, Room 6M5 San Francisco, CA 94110 phone: 415/206-3086 fax: 415/206-3686

## High-Risk Infant Interagency Council

<b>Planning Effort:</b>	The High Risk Infant Interagency Council (HRIIC) is a countywide network of agencies, organizations and parent/caregivers concerned with infants and young children who have or are at-risk for developmental delays or disabilities and their families. HRIIC is a component of the California Early Start Program. It is one of thirty-two local interagency coordinating areas in California. Its primary functions include promoting and facilitating interagency collaboration, coordination of early intervention services, public awareness and outreach, parent/professional training and the dissemination of information.
<b>Mission/Goals:</b>	<p>HRIIC's mission is to insure that all children birth to three years of age in the City and County of San Francisco, who are at risk for or who have developmental delays, receive family centered early intervention services in a timely and coordinated manner, through interagency collaboration.</p> <p>The purposes of the Council include:</p> <ul style="list-style-type: none"> <li>• Providing a forum for parent/professional collaboration;</li> <li>• Serving as clearinghouse and forum for information sharing and communication;</li> <li>• Providing an arena for review and discussion of the early intervention service delivery system;</li> <li>• Supporting interagency decision making;</li> <li>• Coordinating public awareness efforts;</li> <li>• Coordinating local training efforts; and</li> <li>• Providing linkages to the state's Early Start programs.</li> </ul>
<b>Membership:</b>	The Council consists of representatives from: Golden Gate Regional Center, SFUSD, San Francisco Department of Public Health - Mental Health and Substance Abuse Services, California Children's Services, and California Health and Disability Prevention programs, Department of Human Services, Support for Families with Children with Disabilities/Family Resource Center, parents, early intervention programs, members at large which include two child care resource and referral agencies, pediatricians, representatives from Head Start, Child Abuse Prevention Program, and the SF State University Early Childhood Special Education Department.
<b>Staffing:</b>	San Francisco Unified School District - Special Education Unit
<b>Funding Source:</b>	With the implementation of Part H of the Individuals with Disabilities Act (IDEA), federal funds became available to states for the planning and provision of early intervention services for birth to three year olds. As part of this effort, in October 1988, HRIIC became the recipient of a federal grant through California's designated lead agency, the Department of Developmental Services. In September 1993, the California legislature passed SB 1085, implementing Part H in California. The two lead agencies at both the state and local levels are the Department of Developmental Services (Regional Centers) and Education (Special Education). Under implementation of the new entitlement program, HRIIC serves as the local interagency coordinating group for San Francisco county.
<b>Contact:</b>	Liz Kim Program Coordinator

High Risk Infant Interagency Council of San Francisco  
4 Tapia Drive  
San Francisco, CA 94132  
phone: 415/338-6227 fax: 415/469-4786

## Immunization Coalition

<b>Planning Effort:</b>	The San Francisco Immunization Coalition is comprised of public and private health care providers collaborating to achieve and maintain full immunization protection for each child in San Francisco in order to promote community health and wellness.
<b>Mission/Goals:</b>	<p>The mission of the Immunization Coalition is to make preventive health care for children a priority in San Francisco. The Coalition is committed to:</p> <ul style="list-style-type: none"><li>• Achieving on-time immunization of 90% of children by age two by the year 2000;</li><li>• Developing and implementing a city-wide immunization registry;</li><li>• Promoting and providing appropriate immunization information and education;</li><li>• Eliminating barriers to immunization; and</li><li>• Effectively utilizing and coordinating the expertise and resources of Coalition partners.</li></ul>
<b>Membership:</b>	Over 54 participating public and private members including: Department of Public Health, hospitals, private health care providers, child care providers, businesses, service providers, and religious groups.
<b>Staffing:</b>	The first year of the Coalition's activities has been supported through staffing time from the Department of Public Health (70% coordinator, 25% secretary, 50% public service aide). There is extensive voluntary participation from the Coalition's membership.
<b>Funding Source:</b>	Membership donations (\$10,000), Richard and Rhoda Goldman Fund (\$85,000), and in-kind staffing and administrative support from the Department of Public Health (\$93,000). The San Francisco Community Clinic Consortium acts as the fiscal agent for the Coalition.
<b>Contact:</b>	Janet Zola Program Coordinator Department of Public Health 101 Grove Street, Suite 119 San Francisco, CA 94102 phone: 415/554-2625 fax: 415/554-2658

## Mayor's Blue Ribbon Committee on Universal Health Care

<b>Planning Effort:</b>	In November of 1996, the Mayor appointed a Blue Ribbon Committee on Universal Health Care to develop recommendations to the Mayor for improving access to health care for all San Franciscans and especially providing health care coverage to those who are uninsured.
<b>Mission/Goals:</b>	<p>The goals of the Blue Ribbon Committee are to:</p> <ul style="list-style-type: none"><li>• Reduce/eliminate the number of uninsured people living in San Francisco;</li><li>• Provide a standard comprehensive benefits package;</li><li>• Provide a choice of providers and/or health plans;</li><li>• Promote preventive and primary care; and</li><li>• Restructure public sector financing to allow for more flexibility—pooling of categorical funds.</li></ul>
<b>Membership:</b>	The members of the Blue Ribbon Committee represent academic institutions in the Bay Area including the University of California at Berkeley, service providers, small business community, labor organizations, City College of San Francisco, health insurance companies, US Health Care Financing Authority (Region IX), Mayor's Director of Economic Development, and members of the community.
<b>Staffing:</b>	Department of Public Health - Bureau of Children, Youth and Families
<b>Funding Amount:</b>	
<b>Contact:</b>	Mildred Crear Director Maternal and Child Health Department of Public Health - Bureau of Children, Youth and Families 680 8 <sup>th</sup> Street, Suite 200 San Francisco, CA 94103 phone: 415/554-9930 fax 415/554-9678

## San Francisco Breastfeeding Promotion Coalition

<b>Planning Effort:</b>	The San Francisco Breastfeeding Promotion Coalition is an independent group of health care providers, representatives from the community and private industry, government agencies, and parents working together to promote breastfeeding in San Francisco.
<b>Mission/Goals:</b>	The mission of the coalition is to improve the health of the community by promoting breastfeeding as the cultural norm.
<b>Membership:</b>	Members of the San Francisco Breastfeeding Promotion Coalition include, the Fourth Trimester, Homeless Prenatal Program, International Federation of Professional and Technical Engineers—Local 21, Kaiser Medical Center—San Francisco, La Leche League, Lactation Consulting Home Services, Mission Neighborhood Health Center, Mount St. Joseph—St. Elizabeth, Natural Resources, North East Medical Services, Nursing Mothers Counsel—San Francisco Chapter, Parent Voices—San Francisco, Pediatric Referral Group, SF Department of Public Health, San Francisco General Hospital, San Francisco Health Plan, San Francisco Immunization Coalition, San Francisco Medical Society, San Francisco Unified School District—School Health Programs, Sister Mary Philippa Health Center, St. Luke's Hospital, St. Luke's Women's Center, St. Mary's Medical Center, Teenage Pregnancy and Parenting Project, University of California at San Francisco/Stanford Health Care, and Wells Fargo Bank.
<b>Staffing:</b>	<p>The coalition has no full-time staff. All staff time is volunteered by individuals or member organizations. There are six standing work groups:</p> <ul style="list-style-type: none"> <li>• Breastfeeding Policies: Workplace, child care, and institutions</li> <li>• Community Outreach/Cultural and Linguistic Issues</li> <li>• Education</li> <li>• Media/Public Relations</li> <li>• Provider Education</li> <li>• Resource Development</li> </ul>
<b>Funding Source:</b>	The coalition is actively seeking funding for current projects and seed money for staffing and maintaining the coalition.
<b>Contact:</b>	<p>Ann Rojas, MPH, RD            Department of Public Health—WIC Program            680 8<sup>th</sup> Street, Suite 205            San Francisco, CA 94103            ph: 415/554-9728 fax: 415/554-9637</p>

## San Francisco Perinatal Forum

Planning Effort:	<p>The San Francisco Perinatal Forum is a consortium of public and private perinatal service providers. The forum was established in 1982 by the SF Department of Public Health in response to the State Department of Health Services—Maternal and Child Program's goal of regionalization.</p> <p>A State Maternal and Child grant to provide community-based services was awarded to the forum in 1983. From a core group of four prenatal care providers, the forum has grown to include over 20 perinatal and related providers. The forum focuses on funding, grant management, collaboration, continuing education, advocacy, and action.</p> <p>Activities of the San Francisco Perinatal Forum include:</p> <ul style="list-style-type: none"><li>• providing culturally and linguistically appropriate services in community-based settings;</li><li>• conducting provider trainings;</li><li>• coordinating services between member agencies to ensure increased access for more women in San Francisco;</li><li>• conducting routine needs assessments to identify problem areas and service gaps;</li><li>• planning, developing, and implementing collaborative projects and developing recommendations to meet the needs of women in San Francisco; and</li><li>• sharing resources between member agencies including staffing of the forum.</li></ul>
Mission/Goals:	<p>The mission of the forum is to ensure access to appropriate comprehensive perinatal care for all San Francisco residents, with a particular focus on low-income women.</p>
Membership:	
Staffing:	Department of Public Health
Funding Source:	
Contact:	<p>Carol L. Schulte, LCSW Coordinator Comprehensive Perinatal Services Program Department of Public Health 681 8<sup>th</sup> Street, Suite 230 San Francisco, CA 94103 ph: 415/554-9676 fax: 415/554-9678</p>

## San Francisco Starting Points Initiative

<b>Planning Effort:</b>	In 1996, San Francisco was one of fourteen cities and states to be awarded a national Starting Points grant from the Carnegie Corporation of New York. The grant was to create a public/private collaborative to address the needs of young children 0 to 5 and their families. Starting Points established the Early Childhood Interagency Council (ECIC). The Council is comprised of senior representatives from the city departments, service providers, San Francisco Unified School District, private foundations, advocacy groups, and parents.
<b>Mission/Goals:</b>	<p>The mission of Starting Points is to improve the lives of young children and their families in San Francisco through:</p> <ul style="list-style-type: none"> <li>• increased public and private funding for services for young children;</li> <li>• improved services for young children and their families through development of a comprehensive and coordinated delivery system; and</li> <li>• improved planning to meet young children's needs now and in the future.</li> </ul> <p>The goal of Starting Points is to develop and implement a citywide strategic plan focused on improving services for young children (0 to 5) and their families.</p>
<b>Membership:</b>	ECIC membership includes representatives of the Department of Public Health - Division of Mental Health and Substance Abuse Services, Department of Human Services, San Francisco Unified School District, University of California at San Francisco, San Francisco General Hospital, private foundations, direct service providers, advocacy groups, and parents.
<b>Staffing:</b>	Starting Points staff include a director, fiscal policy analyst, program planner, planning associate, and project associate. Staff are housed at the Mayor's Office of Children, Youth and Their Families (MOCYF) and are the planning arm for young children (0 to 5) for MOCYF.
<b>Funding Source:</b>	Carnegie Corporation of New York, Mayor's Office of Children, Youth and Their Families, Miriam and Peter Haas Fund, The San Francisco Foundation, S.H. Cowell Foundation, Evelyn and Walter Haas, Jr. Fund, and Walter and Elise Haas Fund.
<b>Contact:</b>	<p>Lisa Mihaly, Director  San Francisco Starting Points Initiative  Mayor's Office of Children, Youth and Their Families  1390 Market Street, Suite 918  San Francisco, CA 94102  phone: 415/554-8427 fax: 415/554-8965</p>

### Asthma Task Force

Goal: To create a model for asthma management education for elementary school staff, students and parents.

Target: Bayview-Hunter's Point schools and community.

Membership: A collaborative of school staff, Health Department, Health Plans, clinics, community representatives, parents, Lung Association.

Activities: Monthly planning meeting

#### Subcommittees:

- Air Quality/Environment
- Asthma Center
- Curriculum
- Education
- Survey



Mitchell H. Katz, M.D.  
Director of Health

San Francisco Department of Public Health  
101 Grove Street  
San Francisco, CA 94102



Linda Davis  
Interim Superintendent of Schools  
San Francisco Unified School District  
135 Van Ness Avenue  
San Francisco, CA 94102

## CITYWIDE SCHOOL HEALTH PLANNING COMMITTEE

### ROLES AND RESPONSIBILITIES

(As of 7/10/99)

The Citywide School Health Planning Committee convenes under the auspices of the Superintendent of Public Schools and the Director of Health. The Committee serves in an advisory capacity to the Superintendent of Public Schools, the Director of Health and private educational and healthcare institutions that choose to participate.

Its charge involves:

- Identification of health problems most commonly experienced by pre-school and school-aged children
- Development of an inventory of resources, within SFUSD, SFDPH, and City-wide to address those problems
- Review of mandates governing provision of school health services and the child development health programs
- Development of program proposals that would effectively address health problems in a manner that is appropriate to the school environment
- Identification of financing strategies to support those program proposals
- Coordination of efforts to foster collaboration and to avoid duplicative endeavors

### Membership

The Planning Committee is comprised of persons approved by the Superintendent of Public Schools and the Director of Health to form a broadly representative body. This body creates a forum in which experts in youth and adolescent development, education, health and parenting come together to develop effective strategies and programs to improve the health and well-being of children and youth in San Francisco.

### Subcommittees

There are five subcommittees under the full committee including Steering; Assessment; Program; Fiscal Strategies; and Education, Advocacy, and Outreach. Members of subcommittees need not be members of the full committee, but the chairs of those committee should be members of the full committee.

Using a broad definition of health, each subcommittee should consider the impact of the environment when designing activities; resources needed to accomplish goals; authority or approvals required; the

overlapping work of other committees; and the factors emphasized by the Centers for Disease Control and Prevention's 8-Component Model:

- nutrition
- health services
- health education
- physical education
- staff wellness
- counseling and psychological services
- parent-community involvement
- healthy environment

#### Schedule

- The full Planning Committee will meet quarterly.
- The Steering Subcommittee will meet quarterly or as needed.
- The remaining subcommittees will meet as often as determined by the co-chairs of the subcommittee in consultation with the co-chairs of the Steering Subcommittee.



### CalWORKs Behavioral Health and Domestic Violence Council

Federal Welfare Reform legislation (1996) for Temporary Assistance to Needy Families (TANF) states that families may not receive assistance for more than five years during their lifetime. It also mandates that the percentage of TANF families who are working must increase over time, and that virtually all TANF families must work after receiving benefits for one and a half years. California's legislation created the CalWORKs program (California Work Opportunity and Responsibility to Kids) to conform to the new federal law.

A report published by the California Institute for Mental Health noted conclusions from an Urban Institute study (1996). The study concluded, "substance abuse and mental health problems have emerged as one of the primary barriers to employment among welfare recipients. Other identified barriers include physical disabilities, children's health or behavioral problems, domestic violence, housing instability, and learning disabilities. Low basic skills is the most common barrier to employment."

Findings from a 1996 California Institute of Mental Health research project estimate:

- 7-37% as having "diagnosable" substance abuse conditions.
- 30-40% as having "diagnosable" mental health conditions; most often anxiety, depression, Post-Traumatic Stress Syndrome.
- 42% as being victims of childhood physical or sexual abuse and 62% as being victims of domestic violence as adults.

These are complex problems and aggressive timelines. The Department of Human Services transfers \$2.5 Million of State and local funds annually to the Department of Public Health to provide services that can better meet the distinct behavioral health needs of CalWORKs recipients and their families.

Early on, the Department of Public Health convened a CalWORKs Behavioral Health and Domestic Violence Council – comprised of city agency staff, providers, advocates, and peers – to guide San Francisco through this challenge. Council members (1) advise DPH and DHS Administration on issues related to health policies, (2) recommend budget priorities, and (3) design and evaluate delivery systems, outreach and education initiatives, and specific behavioral health and domestic violence programs serving CalWORKs recipients and their families.

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#### **Community Health Services Branch**

• AIDS Health Services • Community Mental Health Services • Community Substance Abuse Services •  
• Housing Services • Maternal Child and Adolescent Health Services • AB75 Tobacco •

1380 Howard St., 4<sup>th</sup> Floor, San Francisco, CA 94102 (415) 255-3744 telephone (415) 252-3062 fax



## **C.2 Service and Health Providers For Children and Childbearing Women.**





# Child Health & Disability Prevention Program

680 - 8th Street, Suite 200, San Francisco, CA 94103  
(415) 554-9950

## MEDICAL PROVIDER REFERRAL LIST DISTRICT #1

### CLINICS:

#### CHILDREN'S HEALTH CENTER SFGH

1001 Potrero Ave., 6M5, 94110

Managed Care Provider: Yes - BC & SFHP

PH: 206-8373

Comprehensive medical services, adolescent medicine, child abuse svs., ref. to dental, Teen Birth Control Clinic--no appt. necessary.

OL: Spanish, Chinese, Vietnamese, Tagalog

TRANS: Muni #47, 9, 25

HOURS: M - F 8 am - 10 pm (after 10 pm referred to Emergency Room), Sat-Sun 1 pm - 9 pm

#### CASTRO-MISSION HEALTH CENTER (H.C. #1)

3850 - 17TH St./Noe, 94114

Managed Care Provider: Yes - BC & SFHP

PH: 487-7500

ELIGIBILITY: SAN FRANCISCO RESIDENT

OL: Spanish, Tagalog

TRANS: Muni 53, 48, 19

HOURS: M - F 8 am - 5 pm

#### MISSION NEIGHBORHOOD HEALTH CENTER

240 Shotwell St./16th St., 94110

Managed Care Provider: Yes - BC & SFHP

PH: 552-3870 x264

OL: Spanish, Tagalog

TRANS: Muni 22, 41, 12, 14

HOURS: Call for appt. & hours.

#### NATIVE AMERICAN HEALTH CENTER

56 Julian Ave., 94103

Managed Care Provider: Yes - SFHP Only.

PH: 621-8051

OL: None

TRANS: Muni 22, 41, 12, 14

HOURS: M - F 9 am - 5 pm

### PRIVATE PHYSICIANS:

#### AGORIO, ENRIQUE (PED.)

1580 Valencia St., #103, 94110

Managed Care Provider: Yes - BC & SFHP

PH: 826-1918

Comprehensive medical svs. to age 21

OL: Spanish

TRANS: Muni 26, 14, 49

HOURS: Call for appt. M, W, TH, F 9-5 pm; T 2-5 pm

#### POTRERO HILL HEALTH CENTER

1050 Wisconsin St./Conn., 94107

Managed Care Provider: Yes - BC & SFHP

PH: 648-3022

OL: Spanish, Tagalog

TRANS: Muni 53, 48, 19

HOURS: M - F 8 am - 5 pm

#### REFUGEE SCREENING CLINIC, SFGH

995 Potrero Ave., Bldg. 80, Ward 85

Managed Care Provider: Yes - BC & SFHP

PH: 206-5333

ELIGIBILITY: LEGAL REFUGEE

OL: Laotian, Cambodian, Viet., Cantonese, Mandarin, Ethiopian, Polish, Bosnian

TRANS: Muni 47, 9

HOURS: M - F 8 am - 5:00 pm

#### ST. LUKE'S NEIGHBORHOOD CLINIC (Int. Med.)

1580 Valencia St., #506 Floor, 94110

Managed Care Provider: Yes - BC & SFHP

PH: 641-6500

14 years old & up

OL: Spanish

TRANS: Muni 14, 26, 49

HOURS: M - F 8:00 am - 5:00 pm. Call for appt.

#### ST. LUKE'S HEALTH CARE CENTER

##### ADOLESCENT SERVICES

1580 Valencia St., #508 Floor, 94110

Managed Care Provider: Yes - BC & SFHP

PH: 285-0448

OL: Spanish

TRANS: Muni 14, 26, 49

HOURS: M - F 9:00 am - 5:00 pm. Call for appt.

#### ALIKPALA, AGNES (PED.) ACCEPTS LOW INCOME

##### CHDP REFERRALS ONLY

1580 Valencia St., #601, 94110

PH: 285-6210

Comprehensive medical svs. to age 21

OL: Spanish, Tagalog

TRANS: Muni 14, 26, 49

HOURS: M, T, TH, F 9 - 5; W - 9-12

**ESCOBAR, ENGRACIA. (PED.)**

3139 Mission St., 94110

Managed Care Provider: Yes - BC &amp; Bay Care

PH: 285-3536

OL: Tagalog, Spanish

TRANS: Muni 14, 12

HOURS: M - F 9:30 am - 5 pm

**SCHWANKE, JAMES (PED.)****Limited Medi-Cal & BC**3700 - 24<sup>th</sup> St., 94114

PH: 641-1019

OL: Spanish

TRANS: Muni 48, J

HOURS: M - TH 9 am - 6 pm

**GOLDEN GATE MEDICAL GROUP**

(Drs. Franzi &amp; Duffield)

3620 Army St./Guerrero, 94110

Managed Care Provider: Yes - BC &amp; SFHP

PH: 826-7575

OL: Spanish, Tagalog

TRANS: Muni 26, 12, 14

HOURS: M - F 9 am - 6 pm. Call for appt.

**GRANADER, LAWRENCE (PED.)**

1580 Valencia St., #803 B, 94110

Comprehensive medical svcs. to age 21 yrs.

Managed Care Provider: Yes - BC &amp; SFHP

PH: 826-4735

OL: Spanish

TRANS: Muni 26, 14, 49, 67

HOURS: M, T, TH, F 10 am - 6 pm; Call for appts.

Closed Wednesdays

**HASKIN, DAVID (PED.)**

1580 Valencia St., Ste. 601, 94110

Comprehensive medical svcs. to age 21 yrs.

Managed Care Provider: Yes - BC &amp; SFHP

PH: 826-7711

OL: Spanish

TRANS: Muni 12, 14, 26

HOURS: M, T, W, F 9 am - 5 pm; TH 9 am - noon

**LOPEZ, GINA P. (PED.)**

1580 Valencia St., Ste 111, 94110

Managed Care Provider: Yes - BC Only

PH: 285-1828

OL: Spanish

TRANS: Muni 12, 14, 26

HOURS: M, T, F 9:30 am - 5 pm; W 9:30-Noon;

TH 12:30 - 5 pm by appt. Closed 12-1:30 pm

**MORALES, MANUEL (INT. MED.)**

2480 Mission St., #213, 94110

Comprehensive medical svcs. 14 yrs. &amp; up

Managed Care Provider: Yes - BC &amp; SFHP

PH: 648-2119

OL: Spanish, Italian

TRANS: Muni 26, 14

HOURS: M - F 11 a.m. - 5 p.m.

**ORTIZ, CESAR (FAM. PRACT.)**

3085 - 24TH ST., #203, 94110

Managed Care Provider: Yes - BC &amp; SFHP

PH: 648-5900

OL: Tagalog, Ilucano

TRANS: Muni 48, 67

HOURS: M, T, W, F 1 pm - 6 pm; TH Closed

**SHAMASH, KAMAL (FAM. PRACT.)****Accepts low income CHDP referrals**

1580 Valencia St., #605, 94110

PH: 821-9393

OL: Spanish, Tagalog

TRANS: Muni 26, 14, 12

HOURS: M - F 9 am - 5 pm

**DISTRICT #2**

(Rev. 4/99)

**CLINICS:****CALIFORNIA CAMPUS HOSPITAL***(Previously Children's Hospital, S.F.)*

3801 Sacramento St./Maple, 94118

Managed Care Provider: Yes - BC &amp; SFHP

PH: 668-8211

Comprehensive medical svcs. to age 17 yrs.

OL: Cantonese, Spanish

Trans: Muni 1, 4, 33

HOURS: M - F 8:30 am - 4:30 pm

Tuesday 5 - 6:30 pm Call for appointment.

**COLE STREET YOUTH CLINIC**

555 Cole St., Suite 6/Haight, 94117

Managed Care Provider: Yes - SFHP

PH: 751-8181

Comprehensive medical services for youth 12 services, i.e. HIV testing, mental hlth. svcs.+

OL: Spanish

TRANS: Muni 6, 7, 33, 66, 71, 43

HOURS: Call for appt. &amp; hours. Open M - F

**PRIVATE PHYSICIANS:****CHIN, JOYCE (PED.)**

2800 Fulton St./4th Ave., 94118

Managed Care Provider: Yes - BC &amp; SFHP

PH: 752-6274

Comprehensive medical svcs. to age 21 yrs.

OL: Chinese

TRANS: Muni 5, 21

HOURS: M, W, TH, F 2 pm - 6 pm; Sat. 2 - 5 pm;

**CLOSED TUESDAY****KAUFMAN, STEPHEN (PED.)**

3905 Sacramento St., #205/Cherry, 94118

Managed Care Provider: Yes - Blue Cross

PH: 752-3664

Comprehensive medical svcs. to age 21 yrs.

OL: None.

TRANS: Muni 1, 4

HOURS: M, T, TH, F 1 pm - 5 pm; W 10 am - 12 pm

**KHIDEKEL, IRINA (PED.)**

3635 California St., 94118

Managed Care Provider: Yes - Blue Cross

PH: 752-0277

Comprehensive medical svcs. to age 18 yrs.

OL: Russian

TRANS: Muni 1, 4

HOURS: T, TH 12 - 8 p.m. Call for appointment.

**HAIGHT ASHBURY FREE MEDICAL CENTER**

No Medi-Cal patients-will take CHDP 200%rs.

558 Clayton St., 94117

PH: 487-5632

OL: Spanish

TRANS: Muni 77, 7, 43

HOURS: M - W 1 - 9 pm; TH-F 1 - 5 pm.

**MAXINE HALL HEALTH CENTER (H.C. #2)**

1301 Pierce St./Ellis, 94115

Managed Care Provider: Yes - BC &amp; SFHP

PH: 292-1300

ELIGIBILITY: SAN FRANCISCO RESIDENT

OL: Chinese, Spanish

TRANS: Muni 38, 31

HOURS: M - F 8 am - 5 pm

**KIYASU, WILLIAM/FAKUDA, YASUKO MDS (PEDS)**

3905 Sacramento St., #303/Cherry, 94118

Managed Care Provider: NO - WILL ACCEPT LOW-

**INCOME CHDP REFERRALS AND STRAIGHT****MEDI-CAL.**

PH: 752-8038

Comprehensive medical svcs. to age 18 yrs.

OL: Japanese

TRANS: Muni 1, 4

HOURS: M - F 9 am - 5:30 pm Call for appointment.

**LIEU, KO MYONG (FAM MED & NEUROLOGY)**

1610 Post St., #202, 94115

Managed Care Provider: Blue Cross

PH: 346-2777

OL: Korean

TRANS: Muni 38

HOURS: M - F 9:30 - 5 pm

**LUZ, LESTER A. (PED.) WILL ACCEPT CHILDREN 5 YEARS AND UNDER ONLY**

2000 Van Ness, #303, 94109

PH: 776-1694

OL: Portuguese, Spanish

TRANS: Muni 47, 49

HOURS: M - F 10 am - 4:30 pm

NUDEL, BELLA (FAM PRAC.)

KATSNELSON, ILANA, (PED)

2211 Post St., #303, 94115

Managed Care Provider: Yes. BC/SFHP

PH: 928-2110

Children Ages 6 & up

OL: Russian

TRANS: Muni 38, 2

HOURS: M, T, TH, F 9:30 am - 4:30 pm

ORYOL, SAM (G.P.)

3838 California St., #601, 94118

Managed Care Provider: Yes - Blue Cross Only

PH: 876-0007

OL: Russian

TRANS: Muni 1

HOURS: M, W, F 10 am - 5 pm; T, TH 12 pm - 7 pm

PACIFIC PEDIATRICS MED. GRP. (ROSE/KELLY/SOLOMON MDs)

2100 Webster St., #326, 94115

Managed Care Provider: Yes - Blue Cross Only.

PH: 923-3588

Comprehensive medical svcs. to age 18 yrs.

OL: Chinese, Vietnamese

TRANS: Muni 1, 22, 38

HOURS: M - F 8:30 am - 5 pm

SOHN, DONG S. (PED.)

1630 Geary Blvd., 94115

Managed Care Providers: Yes - Blue Cross Only.

PH: 931-0809

Comprehensive medical svcs. to age 18 yrs.

OL: Korean

TRANS: Muni 38

HOURS: M - F 9 am - 5 pm

TANG, DIANA & HUIE, SONJA (PEDS)

3905 Sacramento St., #304, 94118

Managed Care Providers: Yes - Blue Cross Only.

PH: 379-6700

Comprehensive medical care to 21 yrs.

OL: Spanish

TRANS: Muni 1, 4

HOURS: M, W, TH, F 10 am - 5 p.m.;

Tues. 10 a.m. - noon

TAGGART, E. ALLEN (PED.)

726 Ashbury St., 94117

Managed Care Providers: Yes - Blue Cross Only.

PH: 752-5301

Comprehensive medical care to 20 yrs.

OL: None

TRANS: Muni 1, 4

HOURS: M - F 2 pm - 5 pm

CHDP MEDICAL PROVIDER REFERRAL LIST  
**DISTRICT #3**  
(Rev. 4/99)

**CLINICS:**

**SILVER AVENUE FAMILY HEALTH CENTER (H.C. #3)**

1525 Silver Ave./San Bruno 94134

Managed Care Provider: Yes. BC & SFHP

PH: 715-0300

ELIGIBILITY: San Francisco Resident

OL: Spanish, Chinese, Tagalog

TRANS: Muni 9

HOURS: M - F 8 am - 5 p.m. Call for appointment.

**SOUTHEAST HEALTH CENTER**

2401 Keith/Armstrong & Carol, 94124

Managed Care Provider: Yes. SFHP Only.

PH: 715-4000

Comprehensive medical/dental services.

OL: Spanish, Tagalog

TRANS: Muni 15

HOURS: M - F 8:00 am - 5:00 pm

**PRIVATE PHYSICIANS:**

**DUDERSTADT, KAREN, RN, MS, PNP (PED. OFFICE)**

1640 Valencia St., #204, 94110

Managed Care Provider: Yes. BC & SFHP

PH: 647-3666

Comprehensive medical svcs. to age 21 yrs.

OL: Spanish

TRANS: Muni 25, 26, 14, 49

HOURS: M - F 9 am - 6 pm

**THE EXCELSIOR GROUP**

4434 Mission Street, 94112

Managed Care Provider: Yes. BC & SFHP

PH: 647-3666

Comprehensive medical svcs. to age 21 yrs.

OL: Spanish, Cantonese, Mandarin, Italian,

French, Hebrew

TRANS: Muni 14, 49

HOURS: M - F 9 am - 6 pm

**GRAVES, BOBBIE (PED.)**

6315 - 3RD ST., 94124

Managed Care Provider: Yes. BC & SFHP

PH: 467-3880

Comprehensive medical svcs. to age 18 yrs.

OL: None

TRANS: Muni 15

HOURS: M - F 10 am - 5 pm. Call for appointment.

**MANIO, CLEMENTINA (PED.)**

2460 Mission St., #106, 94110

Managed Care Provider: Yes. SFHP Only.

PH: 648-7688

Comprehensive medical svcs. to age 20 yrs.

OL: Tagalog, Spanish

TRANS: Muni 14, 26

HOURS: Tue. - Thurs. 9 a.m. - 5 p.m.

**PHAN, HIEUCAM (PED)/CHU, KEVIN (PED)**

1640 - Valencia, Ste. 102, 94110

Managed Care Provider: Yes - BC & SFHP

PH: 285-2006

OL: Spanish, Chinese, Vietnamese

TRANS: Muni 14, 26, 49

HOURS: M, W, TH 9 am - 5 pm, T 10 am - 5 pm

**VILLACORTA, VICTOR (PED)**

3085-24<sup>TH</sup> ST., 94110

Managed Care Provider: Yes - BC & SFHP

PH: 647-8111

OL: Spanish, Tagalog

TRANS: Muni 14, 48

HOURS: M-F

9 AM - 12:30PM, 1:30 PM- 5 PM

**DISTRICT #4**

(Rev. 4/99)

**CLINICS:****BAY AREA ADDICTION RESEARCH & TREATMENT INC. (BAART) & FAMILY ADDICTION CENTER FOR EDUCATION & TRAINING (FACET)**

1040 Geary St.

Managed Care Provider: Yes - BC &amp; SFHP

PH: 563-9816

ELIGIBILITY: Infants, children and mothers with substance abuse problems. Comprehensive medical services. Please call for more information.

OL: Spanish

TRANS: Muni 38

HOURS: M - F 7 am - 3 pm

**CHINATOWN PUBLIC HEALTH CENTER (H.C. #4)**

1490 Mason St./Broadway, 94133

Managed Care Provider: Yes.

PH: 705-8500

ELIGIBILITY: SAN FRANCISCO RESIDENT

OL: Chinese, Laotian, Cambodian, Vietnamese, Burmese, Spanish

TRANS: Muni 30, Cable Car: Powell &amp; Mason

HOURS: M - F 8 am - 5 pm. Call for an appointment.

**LARKIN STREET YOUTH MEDICAL CLINIC (DPH)**

1044 Larkin Street, 94109

Managed Care Provider: Yes - SFHP (CHN)

Comprehensive medical svcs. for youth 12 - 22 years old. Call for more information re. services, i.e. HIV testing up to 25<sup>th</sup> birthday, mental health svcs.+

PH: 673-0911 X 232

OL: Spanish

TRANS: Muni 4, 19, 45

HOURS: M - F. Call for hours and appointments.

**PRIVATE PHYSICIANS:****DO. TUONG DINH (FAM. PRACT.)**

352 Leavenworth, 94102

Managed Care Provider: Yes.

PH: 668-6655

OL: Vietnamese, Cantonese, Mandarin

TRANS: Muni 31, 27, 38

HOURS: M - F 1 pm - 5:30 pm. Sat. 1-3:30 p.m.

Call for appointment.

**KHONG. DOAN MINH (INT. MED.)**

324 Leavenworth St., 94102

Managed Care Provider: Yes

PH: 441-4424

OL: Vietnamese, Chinese

TRANS: Muni 31, 38, 27

HOURS: M, T, TH, F 9 am - 5 pm; W 9 am - 2 pm

Sat 9 am - 2 pm

**NORTHEAST MEDICAL SERVICES**

1520 Stockton St./Columbus, 94133

Managed Care Provider: Yes.

PH: 391-9686

Comprehensive medical and dental services

OL: Cantonese, Mandarin, Tagalog, Vietnamese

TRANS: Muni 30, 41, 15

HOURS: M - F 8:30 am - 5 pm; Sat. 9 am - 4 pm

**SOUTH OF MARKET HEALTH CENTER**

551 Minna St./Russ, 94103

Managed Care Provider: Yes - BC &amp; SFHP

Eligibility: San Francisco Resident

PH: 626-2951

Comprehensive medical and dental services

OL: Spanish, Tagalog, Mandarin

TRANS: Muni 14, I, M

HOURS: M - TH 8 am - 5 pm; F 8 am - 1 pm;

Sat 8:30 am - 1:30 pm

**KUO. SU-MUI (PED.)**

950 Stockton, #205, 94108

Managed Care Provider: Yes

PH: 989-1453

Comprehensive medical svcs. to age 18.

OL: Mandarin, Cantonese, Taiwanese

TRANS: Muni 30

HOURS: M, T, W, F 9 am - 4:30 pm; TH &amp; Sat. 9-noon

**KWAN. TINA (PED.)**

950 Stockton, #207, 94108

Managed Care Provider: Yes

PH: 399-9646

Comprehensive medical svcs. to age 18.

OL: Mandarin, Cantonese

TRANS: Muni 30, 15

HOURS: T, F, Sat 9 am - 12 pm;

M, W &amp; TH 9 am - 5 pm

**DISTRICT #5**

(Rev. 4/99)

**CLINICS:****OCEAN-PARK HEALTH CENTER (H.C. #5)**

1351 24th Ave./Irving, 94122

Managed Care Provider: Yes

PH: 753-8100

ELIGIBILITY: SAN FRANCISCO RESIDENT

OL: Chinese

TRANS: Muni N, 71

HOURS: M - F 8 am - 5 pm

**OMI PROP. J SATTELITE CLINIC - Satellite of Ocean  
Park Health Center - SCREENING ONLY, FOLLOW-UP at  
Ocean-Park Health Center**

446 Randolph St., 94132

Managed Care Provider: Yes.- SFHP

PH: 586-8035

Comprehensive medical services to age 19;

No age limit for HIV testing and counseling.

OL: English Only

TRANS: Muni M

HOURS: Friday 10 a.m. - 6 p.m.

**UNIVERSITY OF CALIFORNIA SAN FRANCISCO****MEDICAL CENTER (UCSF) - STANFORD HEALTH CARE**

400 Parnassus, 94122

Managed Care Provider: Yes SFHP &amp; BC

PH: 476-1000

OL: Sign, Spanish, Arabic, Cantonese, Mandarin,  
Russian, Korean, Farsi

TRANS: Muni N Judah, 43 Marina, 6 Parnassus

HOURS: M - F 8 am - 5 pm; Sat. 9 am - 12:00

**PRIVATE PHYSICIANS:****DO. TUONG DINH (FAM. PRACT.)**

2089 Clement St., 94121

Managed Care Provider: Yes

PH: 668-6655

OL: Vietnamese, Cantonese, Mandarin

TRANS: Muni 2, 38, 1, 38, 28

HOURS: M - Sat. 9 am - 12 noon

**KUO, SU-MUI**

1842 Noriega St.

PH: 566-1734

Comprehensive medical services to 18 years.

OL: Cantonese, Mandarin

TRANS: Muni 71

HOURS: Tues. 8-6 p.m. Thursday 4 p.m. - 6 p.m.

**LEE, CAROL (PED.) ACCEPTS LOW INCOME  
CHDP REFERRALS ONLY**

1518 Noriega St., #200

PH: 566-7556

Comprehensive medical services to 18 years.

OL: Cantonese, Mandarin, Vietnamese

TRANS: Muni 71

HOURS: M - F 10 am-12:30 pm/3-6:30 pm;  
Sat. 9 am - 3:30 pm**LI. RAYMOND (PED.)**

1842 Noriega St./26th Ave.

Managed Care Provider: Yes - BC Only

PH: 566-1734

Comprehensive medical services to 18 years.

OL: Cantonese, Mandarin

TRANS: Muni 71

HOURS: M, W, F 6 pm - 9 pm; TH 3 pm - 7 pm

**LIAU, BERTY (PED.)**

402 8th Ave., Ste. 202, 94118

Managed Care Provider: Yes

PH: 751-1411

Comprehensive medical services to 18 years.

OL: Cantonese, Mandarin

TRANS: Muni 38

HOURS: M, T, W, F 10 am - 6 pm; Sat. 9 am - 2 pm

**PEDIATRIC MEDICAL GROUP OF SAN FRANCISCO**

1569 Sloat Blvd. #314

Managed Care Provider: Yes - BC &amp; SFHP

PH: 476-9697

Comprehensive medical services to 18 years.

OL: Spanish, Tagalog

TRANS: Muni M, K

HOURS: M & TH 8:30 am - 7:45 pm;  
T, W, F 8:30 am - 8:45 pm;  
Sat. 8:30 am - 12:15 - Acute Care Only.

**LEUNG, MARTIN**

950 Stockton, #328, 94108

Managed Care Provider: Yes - BC

PH: 982-5616

Comprehensive medical svcs. to age 18.

OL: Mandarin, Cantonese

TRANS: Muni 30, 15

HOURS: T - 10:30 am - 6 pm; TH 2:30-6 pm;

Sat. 10:30 am - 4 pm

**LI, RAYMOND (PED.)/WONG, KELLY (PED.)**

950 Stockton St., #205, 94108

Managed Care Provider: Yes.

PH: 989-1453

Comprehensive medical svcs. to age 18.

OL: Cantonese, Mandarin

TRANS: MUNI 30

HOURS: M, W, F &amp; Sat 12:30 pm - 4 pm

T - 2 pm - 6:30 pm; TH CLOSED

**LIN, KAO-HONG (PED.)**

728 Pacific Ave., Rm 403, 94133

Managed Care Provider: Yes - BC &amp; SFHP

PH: 982-5858

Comprehensive medical svcs. through 20 yrs.

OL: Mandarin, Cantonese, Taiwanese

TRANS: Muni 30, 45, 15

HOURS: M, T, TH, F 10 am - 5:30 pm; W 10am - 4pm

Sat. 9 am - 1:00 pm

**LOW, SERENE & LOW, RONALD (PED.)**

805 Clay Street

Managed Care Provider: Yes - BC &amp; SFHP

PH: 982-4878

Comprehensive medical svcs. to age 18.

OL: Mandarin, Cantonese

TRANS: Muni 30, 45, 15

HOURS: M - F 10 a.m. - 6 p.m.; Sat. 9 am - 3 p.m.

**MAK, JOSEPHINE (FAM. PRACT.)**

818 Jackson St., #301, 94133

Managed Care Provider: Yes. - BC &amp; SFHP

PH: 398-6624

OL: Cantonese, Mandarin

TRANS: Muni 30

HOURS: Call for appoint. M &amp; Sat. 10 am - 12:30 pm;

T, W, F 10-12/1:30-5:30 pm; TH 1 - 5:30 pm.

**NGUYEN, TIN HUU (PED.)**

518 Ellis St., 94109

Managed Care Provider: Yes - BC &amp; SFHP

PH: 441-6995

Comprehensive medical services to age 18 yrs.

OL: Vietnamese, Cambodian

TRANS: Muni 30, 15

HOURS: M - F 9:30 am - 5 pm; Sat. 9:30 am - 2:30 pm

**PHAM, TUONG DO (FAM. PRACT.)**

456 Ellis St, 94102

Managed Care Provider: Yes - BC &amp; SFHP

PH: 441-4882

OL: Vietnamese, Chinese, Cambodian

TRANS: Muni 30, 15, Cable car

HOURS: M - F 9:30 am - 6 pm; Sat. 9:30 am - 1:30 pm

**RAMER, CYRIL (PED.)**

2000 Van Ness Ave., #706, 94109

Managed Care Provider: Yes - BC &amp; SFHP

PH: 346-9791

Comprehensive care to age 18 yrs.

OL: Tagalog

TRANS: Muni 42, 47, 49

HOURS: M, T, TH 9 am - 5 pm; W &amp; F 9 am - 4 pm

**TANG, JOHN (FAM. PRACT.)**

728 Pacific Ave., #300, 94133

Managed Care Provider: SFHP Only

PH: 781-2598

OL: Cantonese, Mandarin, Spanish

TRANS: Muni 30, 45, 15

HOURS: M - F 9:30 am - 6 pm; Sat. 10 am - noon

**YONG, CAROLINE (PED.)**

950 Stockton St., #205

Managed Care Provider: Yes - BC Only

PH: 989-1453

Comprehensive medical svcs. to age 18.

OL: Cantonese, Mandarin

TRANS: Muni 30

HOURS: M &amp; F 10 am - 1 pm, TH 1:30 pm - 5 pm

**SOLLOD, MITCHELL, INC. (PED.) – ACCEPTS LIMITED  
MEDI-CAL PATIENTS IN FOSTER CARE & LOW INCOME  
CHDP REFERRALS.**

595 Buckingham Way, Ste. 355, 94132

PH: 566-2727

Comprehensive medical services to 18 years.

OL: Spanish, French

TRANS: Muni 29, M, 17; Sam Tran 21A

HOURS: M- F 9 am – 5:30pm

**QUOCK, WINCHELL (PED.)**

402 8th Ave., Ste. 202, 94118

Managed Care Provider: Yes - BC

PH: 751-1411

Comprehensive medical services to 18 years.

OL: Cantonese, Mandarin

TRANS: Muni 38

HOURS: M - F 10 am - 6 pm; Sat. 9 am - 2 pm

**SOROKOWSKI, GEORGE (PED.)**

595 Buckingham Way, Ste. 522, 94132

Managed Care Provider: Yes.

PH: 731-7550

Comprehensive medical services to 17 years.

OL: Ukrainian

TRANS: Muni 28, 18

HOURS: M, W 9:30 am - 5:00 pm;

T & F 9:30 am - 12 noon;

2nd Sat. of each month 10 am - noon

**YONG, CAROLINE (PED.)**

1842 Noriega St.

Managed Care Provider: Yes - BC

PH: 566-1734

OL: Cantonese, Mandarin

TRANS: Muni

HOURS: Please call for appointment.

SAN FRANCISCO CHDP PROVIDERS WHO CURRENTLY  
ARE NOT ACCEPTING NEW REFERRALS  
(Are continuing to see their existing patients only.)

PHYSICIAN NAME	ADDRESS	PHONE #
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DISTRICT #1:

Bodenheimer/Barnes/Bishop/Birnbaum	1580 Valencia St., #201	550-0811
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DISTRICT #2:

Bolton/Rosenbaum/Bernsten	2100 Webster #117	923-3526
Burstein, Leland	3905 Sacramento St., #306	387-2166
Crosby, Katherine	525 Spruce St.	668-8900
Dab, Susan B.	525 Spruce St.	668-8900
Gin, Gary	525 Spruce St.	668-8900
Johnson, Alan	525 Spruce St.	668-8900
Kushner, Joseph H.	3635 California St.	752-2242
Leonards, Laurie N.	525 Spruce St.	668-8900
Phillips, Jane	3905 Sacramento St., #301	386-5354
Piel/Patton/Et. Al	3641 California St.	668-0888
San Francisco Medical	1545 Divisadero	885-8150
Shore, Lawrence	3838 California St., #806	386-5388

DISTRICT #3:

Baca, Rafael (Plans to retire 6/99)	1640 Valencia St., #101	285-1300
Coleman, Arthur	6301 3rd St.	467-1400

**SAN FRANCISCO  
CHILD HEALTH & DISABILITY PREVENTION PROGRAM (CHDP)  
DENTISTS WHO ACCEPT MEDI-CAL AS OF FEBRUARY 1999**

STATUS OF DENTISTS ACCEPTING MEDI-CAL MAY CHANGE AT ANY TIME

NAME	TELEPHONE	ADDRESS	LANGUAGES SPOKEN	AGES
<b><u>DISTRICT #1</u></b> <b><u>CLINICS:</u></b>				
POTRERO HILL HEALTH CENTER	648-7609	1050 WISCONSIN ST.	SPANISH/TAGALOG	5 - UP
U.C.S.F. DENTAL CLINIC @ SAN FRANCISCO	476-5692	1001 POTRERO AVE.	SPANISH	0 - UP
GENERAL HOSPITAL *(CHIP PROVIDER)		BLDG. 20, 2ND FL.		
<b><u>PRIVATE DENTISTS:</u></b>				
CHAVEZ, MARCO	821-0101	2460 MISSION ST., #201	SPAN/SIGN LANGUAGE	2 - UP
NIP, CHARLES *(CHIP PROVIDER)	431-9797 (98)	240 SHOTWELL ST. #230	SPANISH/CHINESE	5 - UP
RENGSTORFF, PETER	285-9900	2440 MISSION ST.	SPANISH	5 - UP
ROCABO, CONNIE	641-7739	2489 MISSION ST. Ste. #6	SPANISH/TAGALOG	7 - UP
SANIDAD, NEMITA	826-8425	2588 MISSION ST #214	TAGALOG	7 - UP
<b><u>DISTRICT #2</u></b> <b><u>CLINICS:</u></b>				
U.C. S.F. BUCHANAN COMMUNITY CLINIC	476-5608	100 BUCHANAN ST.	SPANISH/TAGALOG/CHINESE	3 - UP
U.C. S.F. SCHOOL OF DENTISTRY	476-3276 (CHILD) 476-1891 (ADULT)	707 PARNASSUS AVE. 707 PARNASSUS AVE.	SPANISH/CHINESE	3 - 18 18 - UP
U.O.P. UNIV. PACIFIC SCH. OF DENTISTRY (MEDI-CAL SPEC. NEEDS ONLY)	929-6550 (CHILD) 929-6501 (ADULT)	2155 WEBSTER ST., 1ST. FLOOR 2155 WEBSTER ST., LEVEL C	SPANISH/TAGALOG CANTONESE	2 - 14 14 - UP
ORTHODONTIST	929-6555 (ALL)	2155 WEBSTER ST.,		
<b><u>PRIVATE DENTISTS:</u></b>				
DARKE, CHARLES (Sat. appointments only)	668-8005	2175 HAYES ST.		4 - UP
GOOSBY, ZURETTI	567-2233	2409 SACRAMENTO ST.	SPANISH	11 - 19

NAME	TELEPHONE	ADDRESS	LANGUAGES SPOKEN	AGES
GRINBERG, INESSA	567-2900	2233 POST ST. #102	RUSSIAN	5 - 18
HAEBERLEIN, FRED (PEDODONTIST)	441-7766	1700 CALIFORNIA ST. #200	SPANISH/CHINESE/THAI RUSSIAN/VIETNAMESE	2 - 21
VELADA and BRAGADO	824-0395	3085 24TH ST.	TAGALOG	6 - UP
YOUNG, RONALD *(CHIP PROVIDER) (Wed, Fri, and Sat only)	928-3777	1637 LOMBARD ST.	CANTONESE/SPANISH/CHINESE	3 - UP
<b>DISTRICT #3</b> <b>CLINICS:</b>				
SILVER AVENUE FAMILY HEALTH CENTER (HEALTH CENTER #3)	715-0300	1525 SILVER AVE.	SPANISH/CHINESE	3 - 17
SOUTHEAST HEALTH CENTER	715-4066	2401 KEITH ST.	SPANISH/CANTONESE/TAG	0 - UP
<b>PRIVATE DENTISTS:</b>				
CHURCHWELL, CAESAR	586-3696	933 GENEVA AVE.		4 - UP
FRANK, ROY M. *(CHIP PROVIDER)	822-8210	1425 MENDELL ST.		4 - UP
MADISON, HUEY P.	467-1403	6301 THIRD ST.	SPANISH	5 - UP
MARCOS, ALICIA	239-8511	3998 MISSION ST.	SPANISH/TAGALOG	3 - UP
RELOS, APOLINAR	821-2332 (3)	2460 MISSION ST. #202	TAGALOG/SPANISH	7 - UP
WANG, CHUNG-KUN	648-5100	1580 VALENCIA ST. #605	MANDERIN/SPANISH	5 - UP
<b>DISTRICT #4</b> <b>CLINICS:</b>				
CHINA TOWN PUBLIC HEALTH CENTER (HEALTH CENTER 4)	705-8536	1490 MASON ST.	CHINESE/SPANISH	3 - 16 1/2
NORTHEAST MEDICAL SERVICES	391-9886	1520 STOCKTON ST.	CANT/MAND/VIET/FRENCH	0 - UP
<b>PRIVATE DENTISTS:</b>	399-8888	160 WAVERLY PL. #303 & 304	CANTONESE/VIETNAMESE/ MANDARIN	4 - UP
CHEUNG, ALLAN				
GAMBOA, MICHAEL	989-3648	133 KEARNY #301	TAGALOG/RUSSIAN/SPANISH	6 - UP
LAU, BRUCE	788-1155	CLAY MEDICAL CTR./929 CLAY St. #205	CHINESE/CANT/MANDARIN	5 - UP
LAU, WAI	362-8868	1421 POWELL ST.	CANTONESE/MANDARIN	5 - UP

NAME	TELEPHONE	ADDRESS	LANGUAGES SPOKEN	AGES
LEE, DAVID	982-0133	818 JACKSON ST., #302	CHINESE/MANDARIN/SPANISH	0 - UP
LEE, HENRY/DANNY	398-8797	728 PACIFIC #610	CHINESE/CAN/MAH	1 - UP
LEUNG, GEORGE	362-3388	771 SACRAMENTO	CHINESE /VIETNAMESE	2 - UP
NGUYEN/BIH	391-3323	2041 POWELL	CANT/MAND/VIET/CAMBODIAN	3 - UP
VO, SAM	441-7588	825 VANNESS #301	CHINESE/VIET/FRENCH	3 - UP
YEE, KIN	421-5878	760 MARKET ST. #722	CANTONESE/MANDARIN	5 - UP
<b><u>DISTRICT #5</u></b> <b><u>CLINICS:</u></b>				
<b><u>PRIVATE DENTIST:</u></b>				
BASHA, DIA	664-7866	1569 SLOAT BLVD., #332	SPAN/ARAB/RUS/TAG/FRENCH	3 - UP
BERDICHEVSKY, MIKHAIL	386-5590	4444 GEARY ST. #303	SPANISH, CHINESE, RUSSIAN	10 - UP
CHEW, KA-WING	221-8100	307 6TH ST.	CHINESE	5 - UP
HO, ROBERT	386-0666	307 - 12TH AVE.	VIETNAMESE/CAMBODIAN	6 - UP
JANG AND ASSOCIATES	753-5400	1515 IRVING ST.	CANTONESE/CHINESE	2 - 18
LIPUMANO, LERIDA (PEDODONTIST) - Also sees handicapped children			MANDARIN/TAGALOG	
LIVIZ, ANNA	566-2222	800 SANTIAGO ST. SUITE A	PORTUGUESE	
MA, MICHAEL	386-1314	4216 CALIFORNIA ST. #150	TAGALOG/CHINESE/RUSSIAN	3 - 18
NIDERMAN, PAVEL	564-0740	2310 JUDAH ST.	RUSSIAN/SPANISH/CHINESE	4 - UP
PRICE, COURTNEY	751-5650	5300 GEARY BLVD., #310	RUSSIAN/CHINESE	3 - UP
RAYZBERG, ALEXANDER	387-6063	6304 GEARY BLVD.	RUSSIAN/CHINESE	4 - UP
SCHULZ, JOHN	731-4058	595 BUCKINGHAM Way #331	CHINESE/SPANISH	7 - UP
SIYAHIAN, EDWARD	661-3525	2386 15TH AVE.	ARABIC/ARMENIAN	3 - 18
TIN, JUSTIN	759-7888	2323 NORIEGA ST., #208	CHIN/CAN/MAH/TAG/ITALIAN	7 - UP
TOM, RANDOLPH AND WANG, JOYCE	681-4291	1268 - 20TH AVE.	CHIN/CAN/MAH	2 - UP
YEE, KIN OPEN WED. & EVERY OTHER SAT.)	386-0333	1901 CLEMENT ST.	TOYSHANESE/CAN/MAH	3 - UP
				4 - UP

*San Francisco Community Institutions and Associations*

## **Hospitals**

### **California Pacific Medical Center**

**California Campus**

3700 California Street  
San Francisco, CA 94118  
415-387-8700

**Davies Campus**

45 Castro Street (at Duboce Street)  
San Francisco, CA 94114  
415-565-6000

**Garden Campus**

2750 Geary Blvd.  
San Francisco, CA 94118  
415-563-4321

**Pacific Campus**

2333 Buchanan Street  
San Francisco, CA 94115  
415-563-4321

### **University of California**

**Mt. Zion Campus**

1600 Divisadero  
San Francisco, CA  
415-567-6600

**San Francisco Medical Center**

505 Parnassus Avenue  
San Francisco, CA 94122  
415-476-1000

### **Other Public and Private Hospitals**

**Chinese Hospital**

845 Jackson Street  
San Francisco, CA 94133  
415-982-2400

**Kaiser Permanente Medical Center**

2425 Geary Blvd.  
San Francisco, CA 94109  
415-202-2000

**Kaiser Permanente Medical Center  
French Campus**

4131 Geary Blvd.  
San Francisco, CA 94118  
415-202-2000

**Laguna Honda Hospital &  
Rehabilitation Center**

375 Laguna Honda Blvd.  
San Francisco, CA 94116  
415-759-3360

**San Francisco General Hospital**

1001 Potrero Avenue  
San Francisco, CA 94110  
415-206-8000

**St. Francis Memorial Hospital**

900 Hyde Street  
San Francisco, CA 94109  
415-353-6000

**St. Luke's Hospital**

3555 Army Street  
San Francisco, CA 94110  
415-647-8600

**St. Mary's Medical Center**

450 Stanyan  
San Francisco, CA  
415-668-1000

**Veterans Affairs Medical Center**

4150 Clement Street  
San Francisco, CA 94121  
415-221-4810

## Beacon Centers

<b>Direct Services:</b>	In 1994, the Mayor's Office of Children, Youth and Their Families, the San Francisco Unified School District and the Evelyn and Walter Haas, Jr. Fund - assisted by a community advising group - began planning for Beacon Centers in San Francisco. Beacon Centers are school-based community centers open all day, year-round, which provide opportunities, services, and supports for the healthy development of children, youth, and families in their own communities.
<b>Mission/Goals:</b>	<p>The goals of the Beacon Initiative include:</p> <ul style="list-style-type: none"> <li>• Providing opportunities for young people and families to develop competencies to become more confident, caring and committed members of their communities, through a broad array of activities and services.</li> <li>• Providing young people access to a broader, more coordinated array of services, supports and opportunities that nurture healthy development.</li> <li>• Transforming underutilized public facilities, such as school sites, into neighborhood centers of safety and learning opportunity.</li> </ul>
<b>Membership:</b>	Beacon Centers in San Francisco include: Visitacion Valley Beacon Center, Gateway Beacon Center(Richmond District), Chinatown Beacon Center, Community Bridges Beacon Center (Mission neighborhood), and Sunset Beacon Center.
<b>Staffing:</b>	The initiative is managed by a Steering Committee comprised of the Mayor's Office of Children, Youth and Their Families; San Francisco Unified School District; and Evelyn and Walter Haas, Jr. Fund. Technical assistance to the sites is provided by the Community Network for Youth Development.
<b>Funding Source:</b>	Beacon Centers are funded primarily by the Mayor's Office of Children, Youth and Their Families; Evelyn and Walter Haas, Jr. Fund; S.H. Cowell Foundation; United Way; and the Richard and Rhoda Goldman Fund.
<b>Contact:</b>	<p>Joe Lam            Director of Planning            Mayor's Office of Children, Youth and Their Families            1390 Market Street, Suite 918            San Francisco, CA 94102            phone: 415/554-9519 fax: 415/554-8965</p>

## Family Mosaic Project

<b>Direct Services:</b>	<p>The Family Mosaic Project is one of eight national demonstration projects originally funded in part by the Robert Wood Johnson Foundation Mental Health Services Program for Youth in 1989. The San Francisco Family Mosaic Project is a multi-agency collaborative of service providers that specialize in home, school, and community-based service provision. Family Advocates – teams of multi-agency human service providers – provide intensive case management for children and youth between the ages of 3 and 18 who:</p> <ul style="list-style-type: none"><li>• Have a serious emotional disturbance, or</li><li>• Have a diagnosable mental condition, or</li><li>• Are at-risk of out-of-home placement, or</li><li>• Are already in out-of-home placement.</li></ul> <p>A capitation contract with the state health department allows the Family Mosaic Project to enroll Medi-Cal recipients in an array of mental health and "wrap around" services.</p>
<b>Mission/Goals:</b>	<p>The mission of the Family Mosaic Project is to provide a multi-systemic family intervention and/or wrap-around approach to reconnect children and youth, coming from restrictive levels of care including residential and sub-acute treatment facilities, to home, school, and community-based services.</p>
<b>Membership:</b>	<p>Department of Public Health - Division of Mental Health and Substance Abuse-Child, Adolescent and Family Services Section; San Francisco General Hospital; San Francisco Unified School District; and Juvenile Probation.</p>
<b>Staffing:</b>	<p>Four teams of Family Advocates.</p>
<b>Funding Source:</b>	<p>Robert Wood Johnson Foundation -Mental Health Services Program for Youth Initiative.</p>
<b>Contact:</b>	<p>Miriam Martinez Director Family Mosaic Project 1309 Evans Street San Francisco, CA 94124 phone: 415/206-7600</p>

## Foster Care Mental Health Program

<b>Direct Services:</b>	In accordance with state law (SB 370, passed in 1989), the Foster Care Mental Health Program provides screening, assessment, and referral services for all children currently, or at-risk of being placed in foster care. The program provides consultation and training of cross-agency providers who work with foster care children and their biological, extended, and/or foster families.
<b>Mission/Goals:</b>	<p>The goals of the project are based on the beliefs that:</p> <ul style="list-style-type: none"><li>• The provision of mental health services to children in the foster care system may help stabilize children's living situation, enhance their attachment relationships, and improve their long-term functioning; and</li><li>• A comprehensive screening, assessment, and referral process is critical for managed mental health care in which the Department of Mental Health assumes financial risk for mental health services.</li></ul>
<b>Membership:</b>	Department of Public Health - Division of Mental Health and Department of Human Services.
<b>Staffing:</b>	
<b>Funding Source:</b>	

## Healthy Families

<p><b>Legislation/ Direct Services:</b></p>	<p>In August of 1997, the President authorized the creation of the State Children's Health Insurance Program. This is a ten year, \$47 billion program to provide health care coverage to low-income, uninsured children who's families are below 200% of the poverty line. California's program will be called the Healthy Families program. The program will be administered by the California Managed Risk Medical Insurance Board (MRMIB). The Healthy Families Program is scheduled to begin on July 1, 1998.</p>
<p><b>Mission/Goals:</b></p>	<p><b>California Healthy Families Program</b></p> <p>Program MRMIB will create two options to expand health care coverage to uninsured children: 1) Purchasing Pool Program—will allow families to obtain health care coverage for their children by enrolling in a health plan which contracts with MRMIB; 2) Purchasing Credit Program—will enable families to access employer-sponsored dependent care coverage for their children enrolled in their employer's health plan. Healthy Families includes Local Initiatives (San Francisco Health Plan) and County Organized Health Systems as plan options. Regardless of the program, children will have access to the same scope of benefits that Medi-Cal recipients receive and parents will pay the same co-payments. MRMIB will develop a process to ensure that counties that serve children enrolled in Healthy Families and those that serve also seriously emotionally disturbed children will still be able to submit claims for federal (Medi-Cal??) reimbursement. Families are required to pay monthly premiums and co-payments depending on the income level of the family, the health plan they choose, and whether or not the family pre-pays the first three months. (Monthly premium: \$7 to \$9 per child; co-payment: \$5 per visit, not to exceed \$250 annually per family.)</p> <p><b>Eligibility</b> Children between the ages of 2 and 6 who are between 133% and 200% of the federal poverty level (FPL) and children between the ages of 7 and 18 who are between 100% and 200% of the FPL will be eligible to access health care coverage through Healthy Families. Children between the ages of 0 and 2 under 200% of FPL are ineligible for Healthy Families because they are already covered under Medi-Cal. Children participating in Healthy Families will have continuous eligibility for 12 months. Undocumented children and children of legal immigrants who enter the U.S. after August 22, 1996 are ineligible for coverage under Healthy Families.</p> <p><b>Scope of Services</b> The benefits package will be equivalent to the California Public Employees' Retirement System (PERS) Health Plan. In addition to inpatient and outpatient services, dental and vision services will be available. Children enrolled in the Healthy Families Program will still have access to public health programs, California Health and Disability Prevention (CHDP) program, and the California Children's Services (CCS) program (CCS will be kept as a separate program). Health programs contracting with MRMIB may contract with county mental health departments to provide all or some of the services provided. Healthy Families also directs MRMIB to explore the feasibility of obtaining federal funds to support county drug and alcohol services for children.</p> <p><b>Outreach</b> Outreach efforts will be expanded to enroll children in both Healthy Families and Medi-Cal programs. The Healthy Family program will also pay an application fee to a variety of entities to assist persons to enroll in the new</p>

	program.
<b>Membership:</b>	Health Advisory Board (Is this state or local? What does Tangerine staff? Ask Mildred.)
<b>Staffing:</b>	Department of Public Health
<b>Funding Source:</b>	Funding for this program will come from three sources: 1) federal financial participation; 2) state general funds (state match); and 3) family premiums.
<b>Contact:</b>	Tangerine Bringham Director Office of Planning and Policy Department of Public Health 101 Grove Street, Room 324 San Francisco, CA 94102 phone: 415/554-2613

## Healthy Start Initiative

<b>Planning Effort/ Direct Services:</b>	<p>In 1994/95 the San Francisco Unified School District (SFUSD) was awarded a two year planning grant from the California Department of Education (CDE) to implement the Healthy Start Support Services for Children Act (SB 620, Chapter 790). In San Francisco, approximately eight sites are receiving planning grants and eight more sites receive operational grants to participate in Healthy Start. Healthy Start services are comprehensive, school-linked health and education services that meet the needs of children, youth, and their families in elementary and middle school. Services provided include: nutrition, mental health, substance abuse, and violence prevention and intervention services.</p> <p>Primary schools (K-6) qualify if at least 50% of enrolled pupils are from families who are receiving AFDC benefits or have limited English proficiency and are eligible to receive free or reduced-priced meals. Middle and high schools (grades 7-12) are eligible when at least 35% of enrolled pupils are from families that meet the same criteria.</p>
<b>Mission/Goals:</b>	<p>The mission of Healthy Start is to improve the lives of children and families by:</p> <ul style="list-style-type: none"> <li>• Creating learning environments that are optimally responsive to the physical, emotional, and intellectual needs of each child;</li> <li>• Fostering local interagency collaboration to deliver education and support services to children and their families;</li> <li>• Building on, and working with existing services to children and families to ensure that children of all ages are ready to learn; and</li> <li>• Building on the strengths of children and families and providing opportunities for parents and children to be participants, decisionmakers, and leaders in their communities.</li> </ul>
<b>Staffing:</b>	<p>San Francisco Unified School District (SFUSD) - School Health Programs.</p>
<b>Funding Source:</b>	<p>Four to one state to local match. Planning sites receive \$50,000 per year for one or two years. Operating sites receive \$100,000 in start-up funding plus \$100,000 per year of operation.</p>
<b>Contact:</b>	<p>Trish Bascom Supervisor of School Health Programs San Francisco Unified School District 1512 Golden Gate Avenue SF, CA 94115 phone: 415/749-3400 fax: 415/749-3420</p>

## Infant/Toddler Consortium

<b>Planning Effort:</b>	The Infant/Toddler Consortium is a professional membership organization specifically focused on improving the quality of care for children under the age of three in the San Francisco Bay Area. The Consortium provides low-cost training for caregivers in multiple languages, produces a quarterly newsletter, sponsors center tours, offers referrals for trainers and training programs, offers providers access to its resource library, and advocates for quality child care.
<b>Mission/Goals:</b>	The consortium's mission is to improve the care received by infants and toddlers by providing "on-the-floor" caregivers with training and professional development activities.
<b>Membership:</b>	The consortium has a membership of over 400 individuals and organizations including child care resource and referral agencies, child care centers, family child care providers, community based organizations, educational institutions, Head Start agencies, and others.
<b>Staffing:</b>	The consortium has a part-time administrative assistant. The California Resource and Referral Network is the fiscal agent. Program staffing has been donated by board members and member agencies.
<b>Funding Source:</b>	Consortium activities are supported by foundations, individual contributions, membership fees, and conference/workshop registration fees.
<b>Contact:</b>	Betty Cohen Infant/Toddler Consortium 5232 Claremont Avenue Oakland, CA 94618 ph: 510/638-9189 fax: 510/261-5905

## Medi-Cal/Managed Mental Health Care

Direct Service:	In 1994, California passed the State Assembly Bill 757 requiring counties to provide Medi-Cal beneficiaries with managed mental health care. The state plan for Medi-Cal/Managed Care separates or "carves" mental health services out of the two-plan models for managed physical health care, and gives counties the responsibility for delivering and/or brokering Medi-Cal funded mental health services. Medi-Cal beneficiaries will receive their services through a single, county administered, managed mental health care plan. There may be numerous providers in the mental health care system, but they will all be brokered by the county-run managed care plan.
Mission/Goals:	<p>The mission of the San Francisco County mental health plan is to provide eligible persons of San Francisco with access to a high quality, effective, competitive system of mental health care which is community based, culturally competent, and consumer guided.</p> <p>The goals of San Francisco County mental health plan are to:</p> <ul style="list-style-type: none"><li>• Provide individuals with mental illness the services they need in order to remain in their communities, and prevent deterioration and consequent institutionalization; and</li><li>• Reduce unnecessary health care costs through negotiated contracts with providers and control of service utilization.</li></ul>
Membership:	The City and County of San Francisco, Department of Public Health - Division of Mental Health are responsible for ensuring the delivery of all mental health services to Medi-Cal recipients in San Francisco.
Staffing:	City and County of San Francisco and Department of Public Health - Division of Mental Health.
Funding Source:	
Contact:	

## San Francisco Early Childhood Information System Project

<b>Direct Services:</b>	The San Francisco Early Childhood Information System Project is a public-private collaborative effort to improve access to data on young children, and to improve information sharing via computer linkages with early childhood service providers. The project includes an electronic database service, World Wide Web Site, and resource library/clearinghouse.
<b>Mission/Goals:</b>	<p>The goals of the project are to:</p> <ul style="list-style-type: none"> <li>• Coordinate and analyze existing data/statistics from public and private entities serving young children and their families in San Francisco;</li> <li>• Coordinate the collection of new information to better characterize the population of young children and their service needs;</li> <li>• Regularly infuse information and findings into local children's planning efforts to leverage resources and improve services; and</li> <li>• Provide an electronic forum for key stakeholders to communicate and collaborate more effectively.</li> </ul>
<b>Membership:</b>	<p>The collaborating agencies in the Pilot Network of the San Francisco Early Childhood Information System are:</p> <ul style="list-style-type: none"> <li>• Audrey L. Smith Development Center</li> <li>• Bay Area Women's and Children's Center</li> <li>• California Child Care Resource &amp; Referral Network</li> <li>• Child Care Law Center</li> <li>• Children's Council of San Francisco</li> <li>• Department of Human Services</li> <li>• EOC Head Start of San Francisco</li> <li>• Mayor's Office of Children, Youth and Their Families</li> <li>• Pacific Early Childhood Institute</li> <li>• San Francisco Family Day Care Association</li> <li>• San Francisco Starting Points Initiative</li> <li>• San Francisco Unified School District - Child Development Division</li> <li>• Wu Yee Children's Services</li> </ul>
<b>Staffing:</b>	Full-time project director and part-time administrative support staff.
<b>Funding Source:</b>	Miriam and Peter Haas Fund, The San Francisco Foundation, GAP Foundation, Giants Community Fund, Mayor's Office of Children, Youth and Their Families, and Jennifer Altman Foundation, and U.S. Department of Commerce -National Telecommunications and Information Administration.
<b>Contact:</b>	<p>Julie Beach            Project Director            San Francisco Early Childhood Information System Project            The Children's Council of San Francisco            One Second Street, 4<sup>th</sup> Floor            San Francisco, CA 94105            phone: 415/974-5892 fax: 415/243-4414 web site: <a href="http://www.sfchildnet.org">http://www.sfchildnet.org</a></p>

## San Francisco Health Plan

<b>Direct Services:</b>	<p>In March of 1993, the California Department of Health Services (DHS) announced its Two Plan Model Initiative requiring 12 California counties to move from a fee-for-service Medi-Cal delivery system for AFDC recipients to a managed care model. Under the Two Plan Model, Medi-Cal beneficiaries, mostly low-income mothers and children, are given a choice of enrolling in the San Francisco Health Plan (local initiative plan) or Blue Cross—California Care (commercial plan).</p> <p>The managed care health plan is responsible for providing basic health care services to AFDC recipients. Counties are also required to provide children enrolled in Medi-Cal/Managed Care with health services required by California Health and Disability Prevention (CHDP) and Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Health plans and primary care physicians are required to coordinate with California Children's Services (CCS) to ensure that these children receive CCS services outside of the managed care plan from a CCS provider. Managed care health plans do not include mental health services. Mental health services are provided by a mental health/managed care carve out.</p>	
<b>Mission/Goals:</b>	<p>The goals of enrolling AFDC recipients into a managed care system are to:</p> <ul style="list-style-type: none"> <li>• Reduce service fragmentation;</li> <li>• Increase access to individualized care;</li> <li>• Improve accountability;</li> <li>• Reduce costs; and</li> <li>• Stimulate more appropriate/less restrictive community services.</li> </ul>	
<b>Membership:</b>	San Francisco Department of Public Health and San Francisco Health Authority.	
<b>Staffing:</b>		
<b>Funding Source:</b>		
<b>Contact:</b>	<p>Nancy Presson            Director of Managed Care            Community Health Services            Department of Public Health            1380 Howard Street            San Francisco, CA 94103            phone: 415/255-3632            fax: 415/255-3567</p>	<p>Louise Rogers            Assistant Director of Managed Care            Community Health Services            Department of Public Health            1380 Howard Street            San Francisco, CA 94103            phone: 415/255-3416            fax: 415/255-3567</p>

## Youthline

<b>Direct Services:</b>	Youthline San Francisco is a public/private partnership led by Communities in Harmony Advocating for Learning and Kids (CHALK) and the Mayor's Office of Children, Youth and Their Families (MOCYF). Youthline will be a central information phone-line about services and resources throughout the City for youth. It will provide peer guidance for youth and give first-stage crisis intervention.
<b>Mission/Goals:</b>	<p>The goals of Youthline are to:</p> <ul style="list-style-type: none"><li>• provide every young person with someone who can give a youth-oriented perspective and who is positive, non-judgmental, and supportive;</li><li>• help link San Francisco's youth with positive alternatives, including programs and activities that provide a powerful and safe alternative to street violence, gangs, substance abuse, etc.;</li><li>• provide job training for youth who are employed by Youthline. Listeners develop communication skills, crisis intervention and resolution skills, and the ability to work in teams;</li><li>• connect youth to the crisis services and telephone hot lines they need;</li><li>• provide services to youth in several languages; and</li><li>• gather comprehensive data about the needs and concerns of San Francisco's youth.</li></ul>
<b>Membership:</b>	
<b>Staffing:</b>	The staff of the Youth line project is comprised of a director and Youthline listeners (kids age 16 to 22).
<b>Funding Source:</b>	40% of funding for Youthline comes from the Mayor's Office of Children Youth and Their Families and 60% from private foundations and grants.
<b>Contact:</b>	<p>Pritha Srinivasan Youthline Director 965 Mission Street, Suite 500 San Francisco, CA 94103 phone: 415/538-8580 fax: 415/538-8581</p>



# San Francisco

## Comprehensive Perinatal Services Program

Approved Provider List

January, 2000

Provider	Address	Contact Name	Telephone	Fax
Family Health Center	995 Potrero San Francisco, CA 94110	Daisy Gin	(415) 206-5252	(415) 206-5855
Northeast Medical Services	1520 Stockton San Francisco, CA 94133	Lydia Hsu	(415) 391-9686	(415) 433-4726
Silver Avenue Family Health Center	1525 Silver San Francisco, CA 94134	Karen Casanova	(415) 715-0310	(415) 467-3320
Chinatown Public Health Center	1490 Mason Street San Francisco, CA 94133	Connie Yan	(415) 705-8500	(415) 705-8505
Mount Zion Medical Center	2330 Post Street, 2 <sup>nd</sup> Floor San Francisco, CA 94115	Dr. Elena Gates	(415) 885-7788	(415) 885-7718
Potrero Hill Health Center	1050 Wisconsin San Francisco, CA 94107	Dr. Michael Drennan	(415) 648-3022	(415) 550-1639
Southeast Health Center	2401 Keith San Francisco, CA 94124	Lois Borgmann	(415) 715-4000	(415) 822-3620
Mission Neighborhood Health Center	240 Shotwell San Francisco, CA 94110	Terry Giovannini	(415) 552-3870	(415) 431-3178
San Francisco General Hospital	1001 Potrero, # 5M San Francisco, CA 94110	Mattie Peckenhams	(415) 206-3409	(415) 206-4562
Ocean-Park Health Center	1351 24 <sup>th</sup> Avenue San Francisco, CA 94122	Nelly Fong	(415) 753-8100	(415) 753-8134
South of Market Clinic	551 Minna San Francisco, CA 94103	Christina Sprague	(415) 626-2951	(415) 626-1096
University of California at San Francisco	400 Parnassus, 8 <sup>th</sup> Floor San Francisco, CA 94143	Doris Weyl-Feyling	(415) 476-1112	(415) 476-2196
Planned Parenthood	815 Eddy #200 San Francisco, CA 94109	Vicki Williams	(415) 574-5823	(415) 574-4903
California Pacific Medical Center California Campus	3801 Sacramento San Francisco, CA 94118	Caroline Malter	(415) 346-2229	(415) 752-0469
St. Luke's Women's Center	1580 Valencia, # 506 San Francisco, CA 94110	Monica Mireles-Bravo	(415) 285-7788	(415) 285-6746
	1650 Valencia San Francisco, CA 94110	"	"	"
	6301 Third Street San Francisco, CA 94110	"	"	"
	1580 Valencia, 3 <sup>rd</sup> Floor San Francisco, CA 94110	"	"	"
The Excelsior Group	4434 Mission San Francisco, CA 94112	Sharon Weiner	(415) 406-1353	(415) 452-9307
Maxine Hall Health Center	1301 Pierce San Francisco, CA 94115	Sheila Kerr	(415) 292-1300	(415) 928-6487
Karen P. Tuan, M.D.	660 Sacramento, #300 San Francisco, CA 94111	Dr. Karen Tuan	(415) 398-7178	(415) 398-5525
Richard F. Yee, M.D.	725 Pacific, # 705 San Francisco, CA 94133	Dr. Richard Yee	(415) 986-1515	N/A

Approved but not implementing CPSP as of January, 2000:

Dr. Charles Bookoff, Chinese Hospital, Dr. Lene V.M. Martinez, Dr. Judith Mates,  
Native American Health Center, Sister Mary Philippa Memorial Clinic



## **C.3    Program Funders for Children and Youth**



## Proposition J - The Children's Fund

### Mayor's Office of Children, Youth and Their Families

<b>Legislation:</b>	In 1991, voters in San Francisco passed Proposition J. This amendment to the City Charter set aside a .025 % of local property tax revenues each year specifically for preventive services for children for a ten-year period. The funds set aside are known as the Children's Fund.
<b>Direct Services:</b>	<p>The Mayor's Office of Children, Youth and Their Families (MOCYF) is charged with administering the Children's Fund. A Children's Services Plan (CSP) is developed by MOCYF at the end of each year and sets forth the spending guidelines of the Children's Fund for the following fiscal year. Community input is collected through annual Children and Youth Summits held in various communities of San Francisco.</p> <p>In FY 1997/98, the Children's Fund provided approximately \$14 million for children and youth programs. Approximately \$11 million of the Fund were allocated to 70 community-based organizations by a competitive request for proposal process. Approximately \$2 million of the Children's Fund provided grants to the Department of Human Services, Department of Public Health, Recreation and Parks Department, Private Industry Council, Mayor's Criminal Justice Council, and the San Francisco Unified School District.</p>
<b>Mission/Goals:</b>	The mission of MOCYF is to promote the development of comprehensive programs, policies, and planning strategies aimed at strengthening community-wide efforts to maximize and enhance services for children, youth, and their families.
<b>Staffing:</b>	MOCYF is composed of grant, planning, and fiscal staff. The director of MOCYF is appointed by the Mayor. Starting Points is housed at MOCYF and serves as the early childhood planning staff for MOCYF.
<b>Funding Source:</b>	The Children's Fund is \$.025 of every dollar of local property tax revenues collected in San Francisco. The Children's Fund amounts to approximately \$14 million annually.
<b>Contact:</b>	<p>Winna Davis, Acting Director          Mayor's Office of Children, Youth and Their Families          1390 Market Street, Suite 918          San Francisco, CA 94102          phone: 415/554-8990 fax: 415/554-8965</p>

## Quality Child Care Initiative

<b>Planning Effort:</b>	<p>The Quality Child Care Initiative is a collaboration of early childhood and youth development funders. The Quality Child Care Initiative seeks to increase the availability and quality of child care in the Bay Area, particularly services delivered to the children (ages birth to 12) of parents transitioning from welfare to work and those whose parents are among the working poor. The initiative anticipates allocating up to \$750,000 to support local efforts in the eight counties of Alameda, Contra Costa, Marin, Monterey, San Francisco, San Mateo, Santa Clara, and Santa Cruz.</p> <p>A competitive grant process has been established to support local efforts in five key strategic areas. The five funding priorities are:</p> <ul style="list-style-type: none"> <li>• increased training of new and existing child care providers;</li> <li>• enhancement of child care facilities and environments;</li> <li>• development of coherent linkages between and among agencies responsible for meeting the child care needs of families to assure access to essential information, referrals, and resources;</li> <li>• expanded consumer education to promote increased demand for and utilization of quality child care;</li> <li>• increased and improved advocacy by parents and others directed towards decision makers concerned with the creation, expansion, and maintenance of quality child care.</li> </ul>
<b>Mission/Goals:</b>	<p>The goals of the collaborative are to:</p> <ul style="list-style-type: none"> <li>• increase public and private resources devoted to quality child care in the era of welfare reform;</li> <li>• design and implement a coherent, region-wide, yet locally flexible response to child care needs;</li> <li>• develop a rich database for use in local child care planning and policy decisions;</li> <li>• identify and involve new partners in the philanthropic and government sectors; and</li> <li>• illuminate key issues to increase knowledge of child care in the community.</li> </ul>
<b>Membership:</b>	<p>Membership of the Quality Child Care Initiative includes: The San Francisco Foundation, Trio Foundation, David and Lucile Packard Foundation, Miriam and Peter Haas Fund, the Jennifer Altman Foundation, Luke B. Hancock Foundation, East Bay Community Foundation, S.H. Cowell Foundation, California Endowment, and a number of individual donors.</p>
<b>Staffing:</b>	<p>Miriam and Peter Haas Fund</p>
<b>Funding Source:</b>	<p>The Quality Child Care Fund is funded by The San Francisco Foundation, Trio Foundation, David and Lucile Packard Foundation, Miriam and Peter Haas Fund, and the Jennifer Altman Foundation, Luke B. Hancock Foundation, East Bay Community Foundation, S.H. Cowell Foundation, California Endowment, and a number of individual donors.</p>
<b>Contact:</b>	<p>Yali Lincroft Consultant Quality Child Care Initiative</p>

## **D. Health Status Indicators**

- **FHOP Data and Analysis**
- **Child Health Report – Appendix I**



### **Birth Rate**

The birth rate in San Francisco has declined since 1990 and may very well be due to the shift in demographics of the population within San Francisco, economic forces that are driving families away from the San Francisco as well as a drop in the number of teen pregnancies. Given the expense of living in San Francisco, it should be anticipated that this decline might very well continue into the near future.

### **Distribution of Births by Race/Ethnicity, 1995**

The Asian group was highest among race/ethnic groups for live births in 1995, followed by White, Hispanic and then African American. The other groups represent less than 2% of all other births. This trend should continue given the overall population in San Francisco.

### **Low Birth Weight**

Between 1990 and 1996, San Francisco has seen a drop in the actual numbers of low birth weight infants. The percentages have ranged from a low of 6.4% in 1992 to a high of 7.1% in 1995. San Francisco is still above the Year 2000 objective of 5% of live births and is definitely above the state average for each year listed in the table.

### **Very Low Birth Weight**

San Francisco's rate is above the 1-% figure for the Healthy People 2000 Objective as well as above the state's figure. This would mean 10 fewer babies born with very low birth weight in 1996 compared to 11 fewer babies born with low birth weight in 1990. This is an achievable number.

### **First Trimester onset of prenatal care**

San Francisco is moving in the right direction in relationship to first trimester prenatal care and is very close to the Healthy People 2000 objective of 90% of all pregnant women receiving prenatal care in the first trimester. The percent has steadily risen from a low in 1990 of 74% to a high in 1996 of 86%. Given outreach efforts, both face-to-face and print and electronic media stressing the importance of early prenatal care, this objective should be achieved.

### **Adequacy of Prenatal Care**

The data demonstrates that SF is doing very well in this area. Our percentage is approximately 5 times better than the state percentage for the two periods indicated.

### **Infant Mortality**

San Francisco has exceeded the Healthy People 2000 objective of no more than 7 deaths per 1000 live births. This was exceeded in 1991, 93, 94, 95 and 96.

### **Neonatal Mortality**

Since 1990, San Francisco has exceeded the Healthy People 2000 Objective of no more than 4.5 neonatal deaths per 1000 live births.

### **Post-neonatal Mortality**

San Francisco first exceeded the Healthy People 2000 Objective of no more than 2.5 neonatal deaths per 1000 live births in 1993 and again in 1995 and 1996. There was an increase in 1994, but without more data, it is difficult to state the reason for this increase (more SIDS or injury deaths perhaps?).

### **Fetal Death**

San Francisco had higher ratios than the State of California for all years with the exception of 1994 and had the same ratio as the State of California in 1995. However, the ratio is higher than that expected for the Healthy People 2000 objective of no more than 5 fetal deaths per 1000 live births plus fetal deaths.

### **Teen Births**

The rate of teen births to those less than 15 years has steadily decreased since 1990, from 1.7 to 1.0 in 1996 and is consistently less than the state rates.

In the age group of 15-17 year olds, San Francisco is consistently lower than the State of California rate.

San Francisco is doing much better than the state related to teen births among the 18-19 years olds, with the rates dropping from a high of 67.7 in 1991 to a low of 56.7 in 1996. The state rates have been above 100 except for the 1995 rate.

### **Deaths Due to Unintentional Injuries among Children and Youth**

San Francisco consistently is lower than the Healthy People 2000 Objective of no more than 29.3 per 100,000 people as well as below the State's rate, except for the years 1994-1996.

### **Hospitalizations among Children and Youth Due to Unintentional Injuries**

San Francisco is well below the Healthy People 2000 Objective of no more than 754 per 100,000 population, but still above the State's rate. However, San Francisco's rate is above the State of California's rate for each time period designated.

### **Hospitalizations of females due to violent injuries**

San Francisco is consistently higher than the State of California in regards to this outcome. However, since San Francisco is an urban area this may account for the increased rates in comparison to the state. Furthermore, there has been a downward trend in these rates over the three-year period and the decrease has been greater than that for the State of California.

### **Maternal HIV Infection**

San Francisco has consistently higher rates of maternal HIV infection as determined by testing newborns for all years requested compared to the state. San Francisco has consistently higher rates than the State of California rate, which reflect both rural and urban settings, thus accounting for the lower state rates. Higher rates would consistently be present in large urban areas, and in a city like San Francisco, these rates would be expected. Fortunately, the total numbers are actually low and hopefully will continue to remain low.

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Birth rate**DEFINITION:** The number of live births per 1,000 total population**NUMERATOR:** The number of live births, by place of residence**DENOMINATOR:** The total population, by place of residence**HEALTHY PEOPLE 2000 OBJECTIVE:**  
None**RISK FACTORS:** Not applicable

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Total Births	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	611,666	20.4	20.4	20.5	10,125	13.9	13.6	14.2
1991	609,228	19.9	19.8	19.9	9,868	13.5	13.2	13.7
1992	600,838	19.2	19.1	19.2	9,602	12.9	12.6	13.2
1993	584,483	18.4	18.4	18.5	9,026	12.0	11.8	12.3
1994	567,034	17.6	17.6	17.7	9,051	12.0	11.8	12.3
1995	551,226	17.2	17.1	17.2	8,592	11.4	11.2	11.7
1996		#DIV/0!	#DIV/0!	#DIV/0!	8,368	10.9	10.7	11.1

**Sources:** Vital Statistics of California, 1989-94  
Advance Report, California Vital Statistics, 1995  
Can be analyzed using EpiBC.

**Additional Recommended Tables:**

Births by mother's race/ethnicity -- see template: Distribution of Births by Race/Ethnicity  
Births by mother's age  
Births by mother's education  
Births by geographic area (county and/or ZIP code, if available)  
Births by parity  
Births by method of payment for prenatal care (if available )

Total Births	
DENOMINATOR: Total Population	
State	County
29,976,000	727,900
30,646,000	732,300
31,300,000	744,500
31,746,400	750,800
32,140,000	752,610
32,063,000	751,500
	768,200

Low Birth Weight	
DENOMINATOR: Live Births	
State	County
611,666	10,125
609,228	9,868
600,838	9,602
584,483	9,026
567,034	9,051
551,226	8,592
	8,368

**TITLE V INDICATOR TEMPLATES**

**INDICATOR:** Distribution of births by race/ethnicity, 1995

**DEFINITION:** The proportion of total live births for selected race/ethnic groups

**NUMERATOR:** Number of live births, by race/ethnicity, by place of residence, in a calendar year

**DENOMINATOR:** Total number of live births, by place of residence, in a calendar year

**HEALTHY PEOPLE 2000 OBJECTIVE:**  
None

**RISK FACTORS:** Not applicable

	1995 California				1995 County			
			95% Confidence Interval				95% Confidence Interval	
Births 1995	Number	Percent	Lower	Upper	Number	Percent	Lower	Upper
<b>TOTAL</b>	551,226	100.00%	100.00%	100.00%	8592	100.00%	100.00%	100.00%
Asian	54,475	9.88%	9.80%	9.96%	2895	33.69%	32.69%	34.69%
Black	39,166	7.11%	7.04%	7.17%	1018	11.85%	11.16%	12.53%
Hispanic	253,726	46.03%	45.90%	46.16%	1906	22.18%	21.30%	23.06%
Native Am.	2,735	0.50%	0.48%	0.51%	21	0.24%	0.14%	0.35%
Pacific Isl.	2,763	0.50%	0.48%	0.52%	94	1.09%	0.87%	1.31%
White	196,277	35.61%	35.48%	35.73%	2617	30.46%	29.49%	31.43%
Other	235	0.04%	0.04%	0.05%		0.00%	0.00%	0.00%
Unknown	1,849	0.34%	0.32%	0.35%		0.00%	0.00%	0.00%

**Source:** Advance Report, California Vital Statistics, 1995

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Low birth weight**DEFINITION:** The percent of live born infants weighing less than 2500 grams at birth**NUMERATOR:** The number of infants weighing less than 2500 grams at birth,  
by place of residence, in a calendar year**DENOMINATOR:** The total number of live births, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**

Reduce low birth weight to an incidence of no more than 5 percent of live births. (Baseline: 6.9 percent in 1987) (Objective 14.5)

**RISK FACTORS:**

Young or old maternal age; low income; low maternal education level; race/ethnicity (Black, Puerto Rican, Southeast Asian); high parity; short interpregnancy interval; multiple gestation; unintended pregnancy; history of low birth weight; poor reproductive history; intrauterine growth retardation; preterm birth; prior preterm birth; late entry into prenatal care; lack of comprehensive prenatal care; low pre-pregnancy weight; tobacco use during pregnancy; alcohol/substance abuse during pregnancy; low pregnancy weight gain; placenta previa; premature rupture of the membrane; stress during pregnancy; strenuous exertion during pregnancy

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Low Birth Weight	Number	Percent	Lower	Upper	Number	Percent	Lower	Upper
1990	35,474	5.80%	5.74%	5.86%	681	6.73%	6.24%	7.21%
1991	35,359	5.80%	5.75%	5.86%	743	7.53%	7.01%	8.05%
1992	35,608	5.93%	5.87%	5.99%	615	6.40%	5.92%	6.89%
1993	35,116	6.01%	5.95%	6.07%	625	6.92%	6.40%	7.45%
1994	34,876	6.15%	6.09%	6.21%	605	6.68%	6.17%	7.20%
1995	33,588	6.09%	6.03%	6.16%	610	7.10%	6.56%	7.64%
1996		#DIV/0!	#DIV/0!	#DIV/0!	559	6.68%	6.15%	7.22%

**Source:** Data Matters, Birth Profiles by County and ZIP Code, California, 1989-92  
 Advance Report, California Vital Statistics, 1993-95  
 Can be analyzed using EpiBC

**Additional Recommended Tables:**

Mother's race/ethnicity by birth weight  
 Mother's age (<18, 18-19, 20-34, 35+) by birth weight  
 Mother's education by birth weight  
 Geographic area (county and/or ZIP code, if available) by birth weight  
 Number and percent of low birth weight births by geographic area (ZIP code, if available)  
 Parity by birth weight  
 Trimester prenatal care began by birth weight  
 Kessner index (for Epi BC users) or Kotelchuck APNCU index (if available) by birth weight

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Very low birth weight**DEFINITION:** The percent of live born infants weighing less than 1500 grams at birth**NUMERATOR:** The number of infants weighing less than 1500 grams at birth,  
by place of residence, in a calendar year**DENOMINATOR:** The total number of live births, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**Reduce very low birth weight to an incidence of no more than  
1 percent of live births. (Baseline: 1.2 percent in 1987) (Objective 14.5)**RISK FACTORS:** Preterm birth; prior preterm birth; race/ethnicity (Black, Puerto Rican);  
substance use/abuse (e.g. illicit drug use)

See also risk factors for low birth weight.

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Very Low Birth Weight	Number	Percent	Lower	Upper	Number	Percent	Lower	Upper
1990	6,152	1.01%	0.98%	1.03%	112	1.11%	0.90%	1.31%
1991	6,223	1.02%	1.00%	1.05%	118	1.20%	0.98%	1.41%
1992	6,209	1.03%	1.01%	1.06%	122	1.27%	1.05%	1.49%
1993	6,099	1.04%	1.02%	1.07%	104	1.15%	0.93%	1.37%
1994	6,282	1.11%	1.08%	1.14%	108	1.19%	0.97%	1.42%
1995	5,877	1.07%	1.04%	1.09%	108	1.26%	1.02%	1.49%
1996		#DIV/0!	#DIV/0!	#DIV/0!	93	1.11%	0.89%	1.34%

**Source:** Data Matters, Birth Profiles by County and Zip Code, California, 1989-92  
Advance Report, California Vital Statistics, 1993-95  
Can be analyzed using EpiBC.**Additional Recommended Tables:**

Mother's race/ethnicity by birth weight

Mother's age (&lt;18, 18-19, 20-34, 35+) by birth weight

Mother's education by birth weight

Geographic area (county and/or ZIP code, if available) by birth weight (all birth weights)

Number and percent of very low birth weight births by geographic area (ZIP code, if available)

Parity by birth weight

Trimester prenatal care began by birth weight

Kessner index (for Epi BC users) or Kotelchuck APNCU index (if available) by birth weight

Method of payment for prenatal care, if available, by birth weight

# TITLE V INDICATOR TEMPLATES

**INDICATOR:** First trimester onset of prenatal care

**DEFINITION:** The percent of live-born infants whose mothers received prenatal care in the first trimester of pregnancy

**NUMERATOR:** The number of live births to women who received prenatal care during the first trimester, by place of residence, in a calendar year

**DENOMINATOR:** The total number of live births, by place of residence, in a calendar year

## HEALTHY PEOPLE 2000 OBJECTIVE:

Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.

(Baseline: 76 percent of live births in 1987) (Objective 14.11)\*

## RISK FACTORS FOR NOT OBTAINING EARLY PRENATAL CARE:

Low income; young maternal age/teen pregnancy; low maternal education level race/ethnicity (Black, Hispanic, American Indian/Alaska Native); high parity; maternal substance abuse; lack of health insurance; lack of obstetric providers

	California				County			
			95% Confidence Interval				95% Confidence Interval	
First Trimester Prenatal Care	Number	Percent	Lower	Upper	Number	Percent	Lower	Upper
1990	438,407	71.67%	71.56%	71.79%	7,542	74.49%	73.64%	75.34%
1991	439,733	72.18%	72.07%	72.29%	7,498	75.98%	75.14%	76.83%
1992	447,434	74.47%	74.36%	74.58%	7,554	78.67%	77.85%	79.49%
1993	445,079	76.15%	76.04%	76.26%	7,410	82.10%	81.31%	82.89%
1994	437,094	77.08%	76.97%	77.19%	7,385	81.59%	80.79%	82.39%
1995	431,572	78.29%	78.18%	78.40%	7,237	84.23%	83.46%	85.00%
1996		#DIV/0!	#DIV/0!	#DIV/0!	7,207	86.13%	85.39%	86.87%

**Source:** Data Matters, Birth Profiles by County and Zip Code, California, 1989-92

Advance Report, California Vital Statistics, 1993-95

Can be analyzed using EpiBC.

## Additional Recommended Tables:

Mother's race/ethnicity by trimester of onset of prenatal care

Mother's age (<18, 18-19, 20-34, 35+) by trimester of onset of prenatal care

Mother's education by trimester of onset of prenatal care

Birth weight by trimester of onset of prenatal care

Geographic area (county and/or ZIP code, if available) by trimester of onset of prenatal care

Number and percent receiving late (i.e. after 1st trimester) prenatal care by geographic area: (ZIP code, if available)

Parity by trimester of onset of prenatal care

Method of payment for prenatal care (if available) by trimester of onset of prenatal care

**Note:** \* This measure (based on natality statistics) excludes the prenatal care experiences of all women whose pregnancies did not result in a live birth.

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Adequacy of prenatal care**DEFINITION:** The percent of live-born infants whose mothers did not receive adequate prenatal care as defined by the Kessner Index**NUMERATOR:** The number of live births to women who received "not adequate" care (as defined by the Kessner Index), by place of residence, in a calendar year\***DENOMINATOR:** The total number of live births, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:** None**RISK FACTORS FOR INADEQUATE PRENATAL CARE:**

Low income; young maternal age/teen pregnancy; low maternal education level; race/ethnicity (Black, Hispanic, American Indian/Alaska Native); high parity; maternal substance abuse; lack of health insurance; lack of obstetric providers

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Inadequate Prenatal Care	Number	Percent	Lower	Upper	Number	Percent	Lower	Upper
1991-1993 three year average	216,217	36.15%	36.02%	36.27%	2,126	7.46%	7.16%	7.77%
1992-1994 three year average	198,968	34.06%	33.94%	34.18%	1,894	6.84%	6.55%	7.14%

**Source:** County Health Status Profiles, 1995-96  
Can be analyzed using EpiBC

**Additional Recommended Tables:**

Mother's race/ethnicity by adequacy of prenatal care  
 Mother's age (<18, 18-19, 20-34, 35+) by adequacy of prenatal care  
 Mother's education by adequacy of prenatal care  
 Birth weight by adequacy of prenatal care  
 Geographic area (county and/or ZIP code, if available) by adequacy of prenatal care  
 Number and percent of "not adequate" care by geographic area (ZIP code, if available)  
 Parity by adequacy of prenatal care  
 Method of payment for prenatal care (if available) by adequacy of prenatal care

**Notes:** \* The Kessner Index takes into account three factors -- month in which prenatal care began, number of prenatal care visits, and length of gestation. "Not adequate" prenatal care includes intermediate, inadequate, and unknown adequacy of care. Although many experts believe that other indices may better predict adverse outcomes (e.g. Kotelchuck APNCU), NCHS reports adequacy by the Kessner index only. This measure (based on natality statistics) excludes the prenatal care experiences of all women whose pregnancies did not result in a live birth.

Inadequate Prenatal Care	
DENOMINATOR: Live Births	
State	County
598,183	28,496
584,118	27,679

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Infant mortality**DEFINITION:** The number of infant deaths per 1,000 live births occurring at less than 365 days of age**NUMERATOR:** The number of infant deaths occurring at less than 365 days of age, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**

Reduce the infant mortality rate to no more than 7 per 1,000 live births.  
 (Baseline: 10.1 per 1,000 live births in 1987) (Objective 14.1)  
 No more than 7 infant deaths per 1,000 live births

**RISK FACTORS:**

Race/ethnicity; prematurity/disorders related to short gestation; low birth weight; congenital anomalies; young maternal age; low maternal education level; maternal tobacco use; maternal alcohol or substance use/abuse; poor maternal nutrition; inadequate prenatal care; unintended pregnancy; maternal psychosocial problems; maternal medical complications/ chronic illness during pregnancy (including diabetes); pregnancy complications; short interpregnancy interval; injury (including domestic violence); infection; respiratory distress syndrome; family history of SIDS

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Infant Mortality Rate	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	4,828	7.9	7.7	8.1	73	7.2	5.6	8.9
1991	4,596	7.5	7.3	7.8	64	6.5	4.9	8.1
1992	4,174	6.9	6.7	7.2	69	7.2	5.5	8.9
1993	3,970	6.8	6.6	7.0	45	5.0	3.5	6.4
1994	3,948	7.0	6.7	7.2	74	8.2	6.3	10.0
1995	3,478	6.3	6.1	6.5	37	4.3	2.9	5.7
1996		#DIV/0!	#DIV/0!	#DIV/0!	40	4.8	3.3	6.3

**Source:** Data Matters, Birth Profiles by County and Zip Code, California, 1989-92  
 Advance Report: California Vital Statistics, 1993-95

**Additional Recommended Tables:**

Infant mortality by mother's race/ethnicity  
 Infant mortality by mother's age  
 Infant mortality by mother's education  
 Infant mortality by geographic area (ZIP code, if available)  
 Infant mortality by birth weight category  
 Infant mortality by trimester of onset of prenatal care  
 Infant mortality by Kessner index (for Epi BC users) or Kotelchuck APNCU index (if available)  
 Infant mortality by method of payment for prenatal care (if available)

# TITLE V INDICATOR TEMPLATES

**INDICATOR:** Neonatal mortality

**DEFINITION:** The number of infant deaths per 1,000 live births occurring at less than 28 days of age

**NUMERATOR:** The number of infant deaths occurring at less than 28 days of age, by place of residence, in a calendar year

**DENOMINATOR:** The total number of live births, by place of residence, in a calendar year

## HEALTHY PEOPLE 2000 OBJECTIVE:

Reduce the neonatal mortality rate to no more than 4.5 per 1,000 live births. (Baseline: 6.5 in 1987) (Objective 14.1d)

**RISK FACTORS:** Congenital anomalies; respiratory distress syndrome; short gestation; low birth weight; maternal complications; race/ethnicity (Black, Puerto Rican)

See also risk factors for infant mortality.

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Neonatal Mortality	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	2,959	4.8	4.7	5.0	35	3.5	2.3	4.6
1991	2,774	4.6	4.4	4.7	36	3.6	2.5	4.8
1992	2,545	4.2	4.1	4.4	41	4.3	3.0	5.6
1993	2,429	4.2	4.0	4.3	31	3.4	2.2	4.6
1994	2,467	4.4	4.2	4.5	42	4.6	3.2	6.0
1995	2,164	3.9	3.8	4.1	24	2.8	1.7	3.9
1996		#DIV/0!	#DIV/0!	#DIV/0!	26	3.1	1.9	4.3

**Source:** Data Matters, Birth Profiles by County and Zip Code, California, 1989-92  
Advance Report: California Vital Statistics, 1993-95

## Additional Recommended Tables:

Neonatal mortality by mother's race/ethnicity

Neonatal mortality by mother's age

Neonatal mortality by mother's education

Neonatal mortality by geographic area (ZIP code, if available)

Neonatal mortality by birth weight category

Neonatal mortality by trimester of onset of prenatal care

Neonatal mortality by Kessner index (for Epi BC users) or Kotelchuck APNCU index (if available)

Neonatal mortality by method of payment for prenatal care (if available)

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Post-neonatal mortality**DEFINITION:** The number of infant deaths per 1,000 live births occurring between 28 and 364 days of age**NUMERATOR:** The number of infant deaths occurring at age 28 to 364 days of age, by place of residence, in a calendar year**DENOMINATOR:** The total number of live births, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**

Reduce the post-neonatal mortality rate to no more than 2.5 per 1,000 live births. (Baseline: 3.6 in 1987) (Objective 14.1g)

**RISK FACTORS:** Congenital anomalies; injuries; infection in late pregnancy; family history of SIDS; maternal smoking or drug use; young maternal age (teen births); race/ethnicity (Black, American Indian, Puerto Rican)

See also risk factors for infant mortality.

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Post-Neonatal Mortality	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	1,869	3.1	2.9	3.2	33	3.3	2.1	4.4
1991	1,822	3.0	2.9	3.1	29	2.9	1.9	4.0
1992	1,629	2.7	2.6	2.8	28	2.9	1.8	4.0
1993	1,541	2.6	2.5	2.8	16	1.8	0.9	2.6
1994	1,481	2.6	2.5	2.7	31	3.4	2.2	4.6
1995	1,314	2.4	2.3	2.5	13	1.5	0.7	2.3
1996		#DIV/0!	#DIV/0!	#DIV/0!	14	1.5	0.7	2.3

**Source:** Data Matters, Birth Profiles by County and Zip Code, California, 1989-92  
Advance Report: California Vital Statistics, 1993-95**Additional Recommended Tables:**

Post-neonatal mortality by mother's race/ethnicity

Post-neonatal mortality by mother's age

Post-neonatal mortality by mother's education

Post-neonatal mortality by geographic area (ZIP code, if available)

Post-neonatal mortality by birth weight category

Post-neonatal mortality by trimester of onset of prenatal care

Post-neonatal mortality by Kessner index (for Epi BC users) or Kotelchuck APNCU index

Post-neonatal mortality by method of payment for prenatal care (if available)

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Fetal death**DEFINITION:** The number of fetal deaths of 20 weeks or more gestation per 1,000 live births plus fetal deaths**NUMERATOR:** The number of fetal deaths of 20 weeks or more gestation, by place of residence, in a calendar year**DENOMINATOR:** The total number of live births plus fetal deaths, by place of residence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**

Reduce the fetal death rate (20 or more weeks of gestation) to no more than 5 per 1,000 live births plus fetal deaths. (Baseline: 7.6 per 1,000 live births plus fetal deaths in 1987) (Objective 14.2)

**RISK FACTORS:** Race/ethnicity (Black); maternal diabetes; pregnancy complications; maternal medical complications/chronic illness during pregnancy (including severe maternal infection); Rh sensitization; congenital anomalies; intrauterine cocaine exposure; maternal history of miscarriage

	California				County			
			95% Confidence Interval				95% Confidence Interval	
	Number	Ratio	Lower	Upper	Number	Ratio	Lower	Upper
Fetal Death								
1990	3,989	6.5	6.3	6.7	68	6.7	5.1	8.3
1991	3,834	6.3	6.1	6.5	78	7.9	6.2	9.7
1992	3,704	6.2	6.0	6.4	68	7.1	5.4	8.8
1993	3,574	6.1	5.9	6.3	61	6.8	5.1	8.4
1994	3,299	5.8	5.6	6.0	46	5.1	3.6	6.5
1994	3,355	6.1	5.9	6.3	52	6.1	4.4	7.7
1996		#DIV/0!	#DIV/0!	#DIV/0!	47	5.6	4.0	7.2

**Source:** Vital Statistics of California, 1989-92  
Advance Report, California Vital Statistics, 1993-95

**Additional Recommended Tables:**

Fetal death by mother's race/ethnicity  
Fetal death by mother's age  
Fetal death by mother's education  
Fetal death by geographic area (ZIP code, if available)  
Fetal death by birth weight category  
Fetal death by trimester of onset of prenatal care  
Fetal death by Kessner index (for Epi BC users) or Kotelchuck APNCU index (if available)  
Fetal death by method of payment for prenatal care (if available)

## TITLE V INDICATOR TEMPLATES

**INDICATOR:** Teen births

**DEFINITION:** The number of live births per 1000 adolescent females by age at delivery (less than 15 years of age, 15 to 17 years of age, and 18 to 19 years of age)

**NUMERATOR:** The total number of live births among adolescent females, by age group (less than 15, 15 to 17, 18 to 19), by place of residence, in a calendar year

**DENOMINATOR:** The total number of adolescent females by age group (less than 15, 15 to 17, 18 to 19), by place of residence, in a calendar year

**HEALTHY PEOPLE 2000 OBJECTIVE:**

Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 girls aged 15 through 17 in 1985) (Objective 5.1)\*

**RISK FACTORS:** Low income; low maternal education level; race/ethnicity (Black, Hispanic); lack of effective contraceptive use/family planning practices; lack of education/counseling regarding contraceptive use/family planning; previous teen pregnancy; initiation of sexual activity at a young age

### THE FOLLOWING THREE TABLES STRATIFY TEEN BIRTHS BY AGE GROUP

#### Births to adolescent females younger than 15 years of age

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Births to Teens <15	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	1,390	1.4	1.4	1.5	25	1.7	1.0	2.4
1991	1,469	1.5	1.4	1.5	23	1.5	0.9	2.2
1992	1,595	1.5	1.5	1.6	20	1.3	0.7	1.9
1993	1,572	1.5	1.4	1.5	17	1.1	0.6	1.7
1994	1,687	1.5	1.4	1.6	19	1.3	0.7	1.8
1995	1,640	1.4	1.4	1.5	18	1.2	0.6	1.7
1996		#DIV/0!	#DIV/0!	#DIV/0!	16	1.0	0.5	1.4

**Source:** Vital Statistics of California, 1989-92  
Advance Report, California Vital Statistics, 1993-95  
Denominator Data -- Department of Finance, Demographic Research Unit

**Note:** \*This indicator addresses live births as opposed to pregnancies.

# TITLE V INDICATOR TEMPLATES

INDICATOR: Teen births (continued)

## Births to adolescent females 15 to 17 years of age

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Births to Teens 15 to 17	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	24,828	44.2	43.7	44.7	302	#DIV/0!	#DIV/0!	#DIV/0!
1991	25,914	46.3	45.8	46.9	306	37.1	33.0	41.2
1992	25,967	45.3	44.8	45.8	271	28.7	25.3	32.1
1993	26,301	45.0	44.5	45.6	272	29.7	26.3	33.2
1994	26,378	43.9	43.4	44.5	261	28.7	25.3	32.2
1995	25,821	41.2	40.7	41.7	252	27.7	24.3	31.1
1996	-	#DIV/0!	#DIV/0!	#DIV/0!	218	21.9	19.0	24.8

## Births to adolescent females 18 to 19 years of age

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Births to Teens 18 to 19	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1990	44,732	103.3	102.4	104.2	506	#DIV/0!	#DIV/0!	#DIV/0!
1991	44,408	108.7	107.8	109.7	500	67.7	62.0	73.4
1992	43,305	108.1	107.1	109.0	438	61.6	56.0	67.2
1993	42,218	106.7	105.7	107.7	382	58.0	52.4	63.7
1994	41,820	104.0	103.1	105.0	408	64.4	58.3	70.4
1995	40,823	99.8	98.9	100.7	385	62.3	56.2	68.3
1996	-	#DIV/0!	#DIV/0!	#DIV/0!	370	56.7	51.1	62.3

Source: Vital Statistics of California, 1989-92  
 Advance Report, California Vital Statistics, 1993-95  
 Denominator Data -- Department of Finance, Demographic Research Unit

### Additional Recommended Tables:

Mother's race/ethnicity by mother's age  
 Education by mother's age (<15 and older)  
 Birth weight by mother's age  
 Geographic area (county and/or ZIP code, if available) by mother's age  
 Parity by mother's age  
 Number and percent of births to mothers <18 years of age  
 Trimester of onset of prenatal care by mother's age  
 Kessner index of adequacy of prenatal care by mother's age  
 Method of payment for prenatal care, if available, by mother's age

Females < 15 (i.e. 10 - 14)	
DENOMINATOR:	
State	County
965,382	14,672
1,008,931	14,980
1,039,336	15,010
1,076,500	15,111
1,108,865	15,100
1,135,017	15,114
	16,757

DENOMINATOR: Females 15-17		NUMERATOR: Births to 15-17 year olds					
State	County	State Births, 15 year olds	State Births, 16 year olds	State Births, 17 year olds	County Births, 15 year olds	County Births, 16 year olds	County Births, 17 year olds
561,732		3,807	7,898	13,123	37	103	161
559,364	8,241	3,952	8,545	13,417	51	91	165
573,239	9,443	4,070	8,547	13,350	56	100	113
584,199	9,146	4,279	8,641	13,381	48	102	135
600,321	9,088	4,335	8,701	13,342	49	84	126
626,598	9,094	4,182	8,560	13,079	42	90	120
	9,959				37	75	106

DENOMINATOR: Females 18-19		NUMERATOR: Births to 18 - 19 year olds			
State	County	State Births, 18 year olds	State Births, 19 year olds	County Births, 18 year olds	County Births, 19 year olds
432,985		18,981	25,751	229	276
408,451	7,386	19,423	24,985	216	285
400,778	7,113	18,779	24,526	194	238
395,653	6,584	18,638	23,580	164	233
402,017	6,337	18,548	23,272	179	229
409,045	6,183	18,017	22,806	179	206
	6,530			171	202

## TITLE V INDICATOR TEMPLATES

**INDICATOR:** Deaths due to unintentional injuries among children and youth

**DEFINITION:** The number of deaths due to unintentional injuries (E-codes 800.0-949.9) per 100,000 children and youth (ages 0 through 24 years)

**NUMERATOR:** The number of deaths due to unintentional injuries among children and youth (ages 0 through 24 years), by place of residence

**DENOMINATOR:** The total population (ages 0 through 24 years), by place of residence

### HEALTHY PEOPLE 2000 OBJECTIVE:

Reduce deaths caused by unintentional injuries to no more than 29.3 per 100,000 people (Objective 9.1)

California MCH Five Year Objective: Reduce deaths among children and youth through age 24 caused by unintentional injuries by at least 15 percent.

**RISK FACTORS:** Low income; race/ethnicity (Black, American Indian, Alaska Native); gender (male); inadequate parental supervision/environmental precautions taken; parental/personal alcohol or substance abuse; access to weapons/inadequate firearm regulation/enforcement; lack of health care provider counseling/focus; lack of knowledge about injury protection devices/countermeasures/regulations; lack of consistent legislation/enforcement/use of protective devices; lack of use of sports/recreation protective gear; mental health/developmental disability

### Deaths due to unintentional injuries among children and youth ( ages 0 through 24 years)

	California, Three Year Average				County, Three Year Average			
			95% Confidence Interval				95% Confidence Interval	
Three Year Average	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1989 - 1991	2709	23.9	23.0	24.8	40	20.9	14.4	27.4
1990 - 1992	2493	21.6	20.8	22.4	35	18.3	12.3	24.4
1991 - 1993	2272	19.3	18.5	20.1	33	17.5	11.5	23.4
1992 - 1994	2109	17.6	16.9	18.4	31	16.6	10.8	22.5
1993 - 1995	2112	17.4	16.6	18.1	28	15.1	9.5	20.6
1994 - 1996	1369	11.1	10.5	11.6	27	14.6	9.1	20.0

**Sources:** Microcomputer Injury Surveillance System (MISS), Vital Statistics Section, CDHS  
Population Projections: Department of Finance, Demographic Research Unit

### Recommended Tables:

Leading causes of death due to unintentional injury, by mechanism (e.g., falls, poisoning)

Deaths to children and youth due to unintentional injuries, by mechanism and place of occurrence

Deaths due to motor vehicle crashes among children aged 14 and younger -Objective 9.3a

Deaths due to motor vehicle crashes among youth aged 15 through 24- Objective 9.3b

Deaths due to drowning (E830.0-.9, E832.0-.9, E910.0-.9) among children aged 4 and younger

Deaths due to residential fires and burns (E890.0-E899, E924.0-.9) among children less than 4

Deaths due to suffocation among children less than 4 (E911-E913.9)

Deaths due to unintentional firearm injuries (E922.0-922.9) Reference Objective 7.3

Deaths due to unintentional poisoning injuries (E850.0-E869.9) among children aged 4 and younger

<b>DENOMINATOR: Total population ages 0 through 24</b>		
	<b>State</b>	<b>County</b>
1989	11,175,281	
1990	11,351,613	191,214
1991	11,541,129	190,961
1992	11,750,023	188,785
1993	11,956,912	186,613
1994	12,159,396	185,793
1995	12,377,906	185,494
1996		194,432

<b>NUMERATOR: Deaths among children and youth through age 24 caused by</b>		
	<b>State</b>	<b>County</b>
1989	2,866	41
1990	2,730	37
1991	2,531	42
1992	2,218	27
1993	2,227	29
1994	2,067	36
1995	2,041	19
1996		26

**TITLE V INDICATOR TEMPLATES**

<b>INDICATOR:</b>	<b>Hospitalizations among children and youth due to unintentional injuries</b>
<b>DEFINITION:</b>	The rate per 100,000 children and youth (ages 0 through 24) of hospitalizations due to unintentional injuries (E-codes 800.0-949.9)
<b>NUMERATOR:</b>	The number of hospitalizations to children and youth (ages 0 through 24 years) caused by unintentional injuries (E-codes 800.0-949.9), by place of residence
<b>DENOMINATOR:</b>	The total population ages 0 through 24, by place of residence
<b>HEALTHY PEOPLE 2000 OBJECTIVE:</b>	Reduce unintentional injury hospitalizations to no more than 754 per 100,000 (Objective 9.2)

**Hospitalizations among children and youth through age 24 due to unintentional injuries**

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Year	Number	Rate	Lower	Upper	Number	Rate	Lower	Upper
1993	40,191	336.1	332.9	337.2	703	376.7	348.92	404.51
1994	39,929	328.4	325.2	329.4	648	348.8	321.97	375.58
1995	34,391	277.8	274.9	278.8	608	327.8	301.76	353.78

**Sources:** Hospitalized Injury Surveillance System (HISS), Prepared by the Injury Surveillance and Epidemiology Section, CDHS  
Population Projections: Department of Finance, Demographic Research Unit, 1995

**Additional Recommended Tables:**

Leading causes of hospitalized injuries by mechanism (e.g., motor vehicle, falls, etc.)

Leading causes of hospitalized injuries by age, race/ethnicity and sex

Hospitalizations to children due to unintended poisonings (E850.0-869.9)

Hospitalizations to children due to unintended falls (E880.0-888)

Hospitalizations to young children due to pedal cycle accidents (E826.0-.9)

Hospitalizations to young adolescents due to unintended firearm injuries (E922.0-.9)

Hospitalizations to young adolescents due to motor vehicle crashes (E810.0-825.9)

DENOMINATOR: Total population ages 0 through 24		
	State	County
1993	11,956,912	186,613
1994	12,159,396	185,793
1995	12,377,926	185,494

**FAMILY HEALTH OUTCOMES PROJECT**  
**DOMESTIC VIOLENCE TEMPLATES**

<b>INDICATOR:</b>	<b>Hospitalizations of females due to violent injuries</b>
<b>DEFINITION:</b>	The rate per 100,000 adult women (18 and older) of hospitalizations due to assaultive injuries (E960.0-968.9)
<b>NUMERATOR:</b>	Total number of women hospitalized due to External Causes of injuries (E-Codes) E960.0-E969.9 by place of residence, in a calendar year
<b>DENOMINATOR:</b>	Total adult female population (18 and older), by place of residence in a calendar year
<b>HEALTHY PEOPLE 2000 OBJECTIVE:</b>	None

**Domestic Violence: Hospitalized Violent Injuries to Adult Females (18 and older)**

	California				County			
			95% Confidence Interval				95% Confidence Interval	
Year	Number Hospitalized	Rate	CA Lower CI	CA Upper CI	Number Hospitalized	Rate	County Lower CI	County Upper CI
1993	2,722	28.0	27.0	29.1	202	64.5	55.6	73.4
1994	2,480	25.2	24.2	26.2	157	50.1	42.3	58.0
1995	2,395	24.0	23.0	24.9	133	42.5	35.3	49.7

**Sources:** Hospitalized Injury Surveillance System (HISS), prepared by the Injury Surveillance and Epidemiology Section, CDHS, 1993-1995.  
 California Department of Finance, Population Projections for 1993-1995.

**Recommended Tables:**

Hospitalizations due to violent injuries by mechanism (e.g., firearms, knives, etc.)  
 Hospitalizations due to violent injuries by age category and race/ethnicity

**\*Note:** Because there is no domestic violence-specific external cause of injury (E-Code) in the current International Classification of Diseases, 9th Revision (ICD-9) clinical modification coding, the numerator in this template reflects hospitalizations due to all types of assaults E-Codes E960-968, "Homicide and Injury Purposely Inflicted by Other Person." Recent research shows that a large proportion of the injuries to women requiring some type of medical care are reportedly inflicted by someone known to the woman. Some estimates show, for example, that one in every three injuries reported by women treated in hospitals are inflicted by a current or former husband or boyfriend.

**TITLE V INDICATOR TEMPLATES****INDICATOR:** Maternal HIV infection**DEFINITION:** The number of women with HIV infection per 1,000 live births\***NUMERATOR:** The number of HIV-positive women who delivered live-born infants (as measured through the CDC SCW, adjusted for survey period,\*\*) by state of occurrence, in a calendar year**DENOMINATOR:** The total number of blood specimens tested through the CDC SCW, by state of occurrence, in a calendar year**HEALTHY PEOPLE 2000 OBJECTIVE:**

Confine the prevalence of HIV infection among women giving birth to live-born infants to no more than 100 per 100,000.

(Baseline:150 per 100,000 in 1989) (Objective 18.2c)

**RISK FACTORS:** Young maternal age/teenage pregnancy; low income; race/ethnicity; substance use/abuse (IDU); addiction to crack cocaine; trading sex for drugs/money; transfusion; high risk/unsafe sexual practices (e.g., anal intercourse; multiple sexual partners; high risk sexual partners including injection drug users, HIV-infected, or homosexual contacts)

	California				
Maternal HIV Infection	Number tested	Number HIV+	Rate (per 10,000)	Lower 95% CI	Upper 95% CI
1988-1990	430,586	299	6.9	6.2	7.7
1992	150,494	106	7.0	5.7	8.4
1994	143,095	105	7.3	5.9	8.7

	County				
Maternal HIV Infection	Number tested	Number HIV+	Rate (per 10,000)	Lower 95% CI	Upper 95% CI
1988-1990***	4,985	6	12.0	2.4	21.7
1992	2,442	5	20.5	2.5	38.4
1994	2,293	4	17.4	0.4	34.5

**Source:** California HIV/AIDS Update, Office of AIDS, April 1992  
HIV Seroprevalence in CA Childbearing Women, 1994,  
Office of AIDS, HIV/AIDS Epidemiology Branch**Additional Recommended Tables:**

Mother's race/ethnicity, age, education and geographic area (county and/or ZIP code) by exposure category of mother, if available

**Notes:** \*As estimated through the CDC Anonymous Survey in Childbearing Women (SCW) using leftover heel-stick blood taken from newborn infants in participating states.

\*\*Data for some states are reported in SCW as actual raw numbers, others present adjusted survey numbers reflecting 12-month period.

\*\*\*Does not include data for 1988 (not a



## **E. Qualitative Data**

- **Methodology**

The San Francisco MCAH program used a planning process which utilized current planning groups and their work: The Maternal Child and Adolescent Health Advisory Board and Maternal Child Health staff. Members of the advisory board represent the following constituents: Family Service Agency/ pregnancy teen program, nutrition, pediatric dentist, foster parent, parent of a child with a disability, psychiatrist, pediatrician, and a child care provider. The foundation of the process was data contained in the 1998 Child Health Report produced by MCAH.

Focus groups were conducted with target populations identified by members of the advisory board and population identified by data with the poorest outcomes. Data from the Child Health report was presented to the focus groups for corroboration from the community perspective if the findings were also valid for the recipients of services.

- **Community Needs Assessment: Health Care Access in San Francisco**



*Community Needs Assessment:  
Health Care Access in San Francisco*

*March 1999*

*Prepared For:* Maternal Child, Adolescent Health  
Department of Public Health  
San Francisco CA

*Community Needs Assessment:  
Health Care Access in San Francisco*

*March 1999*



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## Overview

Community health indicators such as prenatal care, low birthweight infants and infant mortality, show San Francisco is well on its way to achieving federal guidelines established by the Healthy People 2000 goals. Yet, this trend is not uniformly experienced throughout all of San Francisco's communities. Lagging significantly behind the general trend toward improved health are the San Francisco communities of Bayview/Hunter's Point, Inner Mission, and the Tenderloin. There are high concentrations of low income residents, ethnic and racial minorities, and immigrant populations located in these communities. Through a series of community focus groups, residents, representative of these population segments, identified many of the following factors as impacting their ability to bear and rear healthy children:

- Environmental factors of air pollution, toxic buildings and soil contamination
- Lack of affordable health care for the working poor
- Insufficient dental health insurance coverage through government subsidized programs; and
- Diminution of quality of service caused by culturally insensitive health care professionals, lengthy waits for service, followed by abbreviated medical examinations.

They suggested that the overall health of their communities would be improved through greater involvement of each community in addressing its health care issues. They believed that:

- Public health administrators could facilitate this community involvement by the inclusion of those negatively impacted residents on advisory boards;
- Training and employing residents as community health information resources;
- Training health care providers to be more tolerant and less judgmental of poor people, especially homeless pregnant women;
- Training medical staff to adopt a team approach to health care that includes the patient as part of the team;
- Expanding government subsidized health coverage to include expanded dental and vision benefits; and
- Providing more recreational programs and activities for youth as a healthy preventative to negative influences.

# Federal Performance Measures Summary Sheet

Core Performance Measures	1997 Data
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Care Needs (CSHCN) Program	
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients	
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."	
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).	
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.	
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.	
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.	
9) Percentage of mothers who breastfeed their infants at hospital discharge.	
10) Percentage of newborns who have been screened for hearing impairments before hospital discharge	
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care	
12) Percent of children without health insurance	
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.	

Shaded Areas: Data Not Available

# Federal Performance Measures Summary Sheet

Core Performance Measures	1997 Data
15) Percent of very low birth weight live births.	1%
16) The rate (per 100,000) of suicides among youths 15-19.	
17) Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates.	88.1%
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	86%

## **II. State Performance Measures**

# State Performance Measures Summary Sheet & 1997 Data

Negotiated Performance Measures	1997 Data
1) Percent of local health jurisdictions with an MCH program supported by the Title V Block Grant	
2) Number of selected domestic violence (DV) services provided by MCH-funded battered women's shelters to demonstrate the State Title V agency has formed a partnership with DV agencies/shelters to expand and enhance local capacity to provide DV services.	
3) The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.	
4) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.	
5) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.	
6) Risk-adjusted perinatal data are made available to birthing hospitals for use in continuous quality improvement (CQI) projects.	
7) The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.	
8) The percent of California Children Services (CSS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.	
9) The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive health exam during the fiscal year.	
10) The percent of CCS children with Cleft Palate, Spina Bifida, and Acute Lymphoid Leukemia who were referred to Special Care Centers for multidisciplinary, coordinated evaluation and treatment plans.	

### **III. 1997 Health Outcomes Templates**

# County 1997 Templates and Data

Templates	1997 Data
< 15 Birth Mothers	
15-17 Birth Mothers	
18-19 Birth Mothers	
Hospitalization Assaulted Females	
Deaths 0-24 from Unintentional Injuries	
Mothers Who Intend to Exclusively Breastfeed	
Low Birth Weight (< 2,500 grams or <5.5 lbs)	5.6%
Very Low Birth Weight (< 1,500 grams)	1%
Onset Prenatal Care First Trimester	
Inadequate Prenatal Care	
Infant Mortality (< 365 days)	
Neonatal Mortality (< 28 days)	
Post-Neonatal Mortality (27-365 days)	
Fetal Death ( $\geq$ Weeks Gestation)	

Shaded Areas: Data Not Available

#### **IV. Focus Group Analysis of 1996 Healthy People 2000 Objectives**

# HEALTH INDICATORS: Focus Group Analysis of 1996 Healthy People 2000 Objectives

## Prenatal Health

Late prenatal care (2nd or 3rd trimester) is considered a health factor for worse outcome including low birth-weight and infant mortality.

HP 2000 Objectives	San Francisco's Health Status	Targeted Health Concerns	Focus Group Analysis
90% of women giving birth receive early prenatal care	86% of women giving birth received early prenatal care	Although San Francisco is close to the HP 2000 objective, there remains concern for African Americans and Latinas who both experienced a lower rate (76%) of first trimester prenatal care compared to women of all other ethnicities. Additionally, only 59% of Pacific Islanders obtained early prenatal care.	<ul style="list-style-type: none"> <li>Focus group participants were aware of the need for early examinations by a doctor within the first 3 months of pregnancy.</li> <li>Access to pregnancy testing for timely determination of pregnancy was thought to be inexpensive and readily available.</li> <li>However, teen mothers suggested that they were initially in a mental state of denial regarding their pregnancy. This emotional anxiety and the time taken to determine whether they would abort or keep the fetus, complicated by the need to inform parents, tended to extend the prenatal period without care. These teens noted that once a decision to seek care was made, waiting for the next available appointment with a doctor would push them to the edge of, or over, the recommended first trimester visit.</li> </ul>

**Low Birthweight**

Infants born weighing under 2500 grams or 5.5 pounds are considered low birthweight and are at risk for physical and developmental complications, as well as, infant mortality.

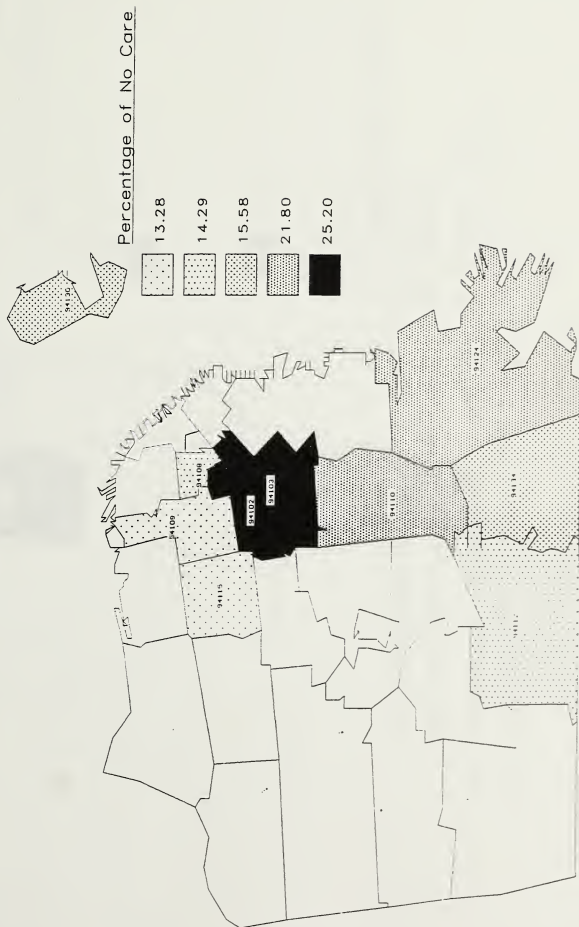
<i>HP 2000 Objectives</i>	<i>San Francisco's Health Status</i>	<i>Targeted Health Concerns</i>	<i>Focus Group Analysis</i>
Incidence of low birthweight reduced to no more than 3% of live births overall and no more than 9% for African Americans	The incidence of low birthweight in the county has been reduced to 6.7% of all births in San Francisco.	Low birthrates still remain high for segments of San Francisco's population. 15.2% of infants born to African American women had low birthweights. While Filipinos and Pacific Islanders had, respectively, the second (9.0%) and third (8.0%) highest incidences of low birthweight. Adolescent mothers (ages 12 to 19) were another population that experienced higher statistics (8.1%) of low birthweight infants.	<ul style="list-style-type: none"> <li>When asked about the proper diet for pregnant women, a focus group of pregnant teens indicated a high level of awareness. They felt nurses clearly stated the nutritional requirements of pregnant women. In fact, these teens complained that the information was too repetitive and communicated in a "boring" way. This made the subject of nutrition a "turn-off" for them.</li> <li>Latina immigrant women believed that it was insufficient for doctors to warn pregnant teens to make "drastic" lifestyle changes to protect their fetuses. These women felt that in order to have youth make changes like alcohol, drug or smoking cessation, it was important to have teens paired with an older female friend or parent during prenatal clinic visits. In this way the young woman was forced into taking responsibility for her babies health. It was suggested that small incentives be offered to teens with a "prenatal coach" to encourage these teens</li> </ul>

**Mortality**

Infant mortality is a universally recognized indicator of health status of a community.

<i>HP 2000 Objectives</i>	<i>San Francisco's Health Status</i>	<i>Targeted Health Concerns</i>	<i>Focus Group Analysis</i>
Reduction of the infant mortality rate for infants under 1 year old to no more than 7 per 1,000 live births	San Francisco's 1996 infant mortality rate for infants under 1 year old was 4.8 deaths per 1,000 live births.	The Healthy People 2000 goal for African American infants under 1 year of age is no more than 11 per 1,000 live births. Although African Americans represented the highest rate among all race/ethnic groups in the City, the infant mortality rate of 12.5 per 1000 births for infants under 1 year nearly met HP2000 objectives.	<ul style="list-style-type: none"> <li>Although San Francisco's youth are able to do comparatively well surviving the first year of life, survival, statistically, was more precarious during years 1 - 4 and markedly challenging during years 15 - 24. This is consistent with teen's stated fears of gang violence, police harassment, and involvement in illegal drug activity.</li> </ul>
Reduction of the mortality rate for youth ages 1 - 4 years old to no more than 28 per 1000	San Francisco's rate for youth ages 1 - 4 was 34.6 per 1000	This exceeds the HP2000 objective.	
Reduction of the mortality rate for youth ages 5 - 14 to no more than 28 per 1000	San Francisco's rate for youth ages 5 - 14 was 19.5 per 1000	San Francisco met the HP2000 objective for this age group.	
Reduction of the mortality rate for youth ages 15 - 24 to no more than 85 per 1000	San Francisco's rate for youth ages 15 - 24 was 106.5 per 1000	San Francisco clearly exceeds the mortality rate deemed acceptable for this age group. The hazards of urban life contributing to this high rate of death appear to increase when youth reach the late adolescence. Death rates for this male population were six times higher than the rates for males 5 - 14; while females in this age group were triple the rate for the next younger group	

# No Prenatal Care in the First Trimester including unknowns by Zip Code for 1996 in The City of San Francisco



# San Francisco Adolescent (12-19) Live Births

By Mother's Residence Zip Code, Top Three Zip Codes, 1996

## Percentage Of Adolescent Live Births Per Adolescent Zip Code Populations

Percentage of Births

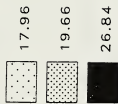


# San Francisco Adolescent Mother's (12-19) Live Births

By Mother's Residence Zip Code, Top Three, 1996

65% Of Adolescent Births Occurs In The Top Three Zip Codes

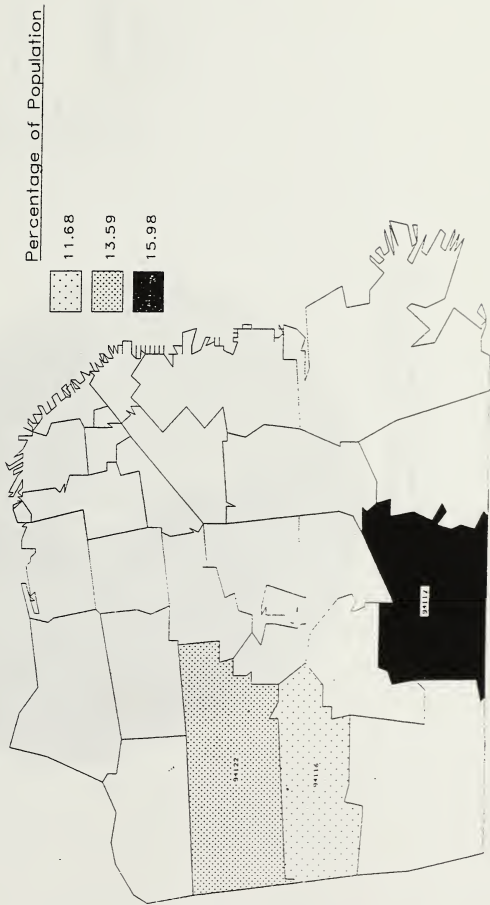
Percentage of Births



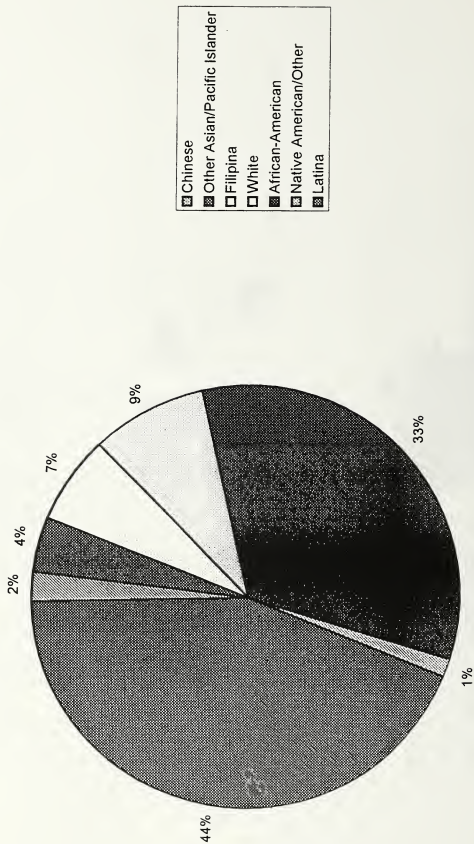
San Francisco African-American Births By Mother's Residence  
Zip Code, Top Three, 1996  
The African-American Infant Mortality Rate Is 322%  
Of The Other Combined Populations



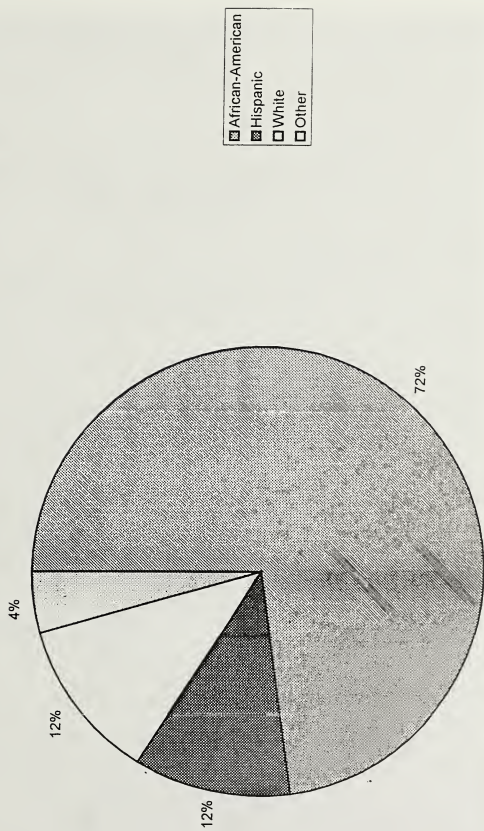
San Francisco Latina Births By Mother's Residence  
Zip Code, Top Three, 1996  
The Latina Infant Mortality Rate Is 165%  
Of The Other Combined Populations



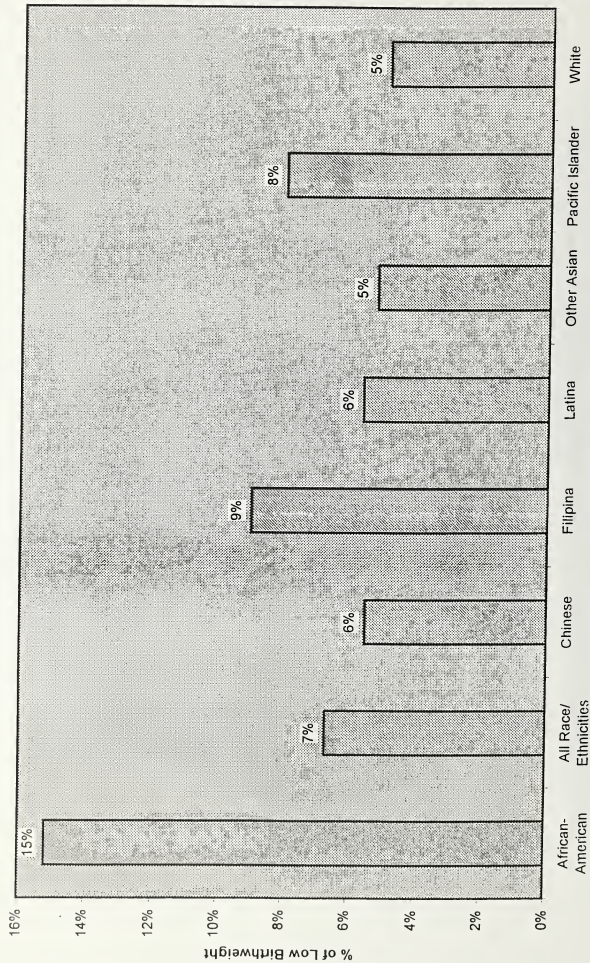
Live Births Adolescent Mothers, Age 12-19  
By Mother's Race/Ethnicity, San Francisco, 1996



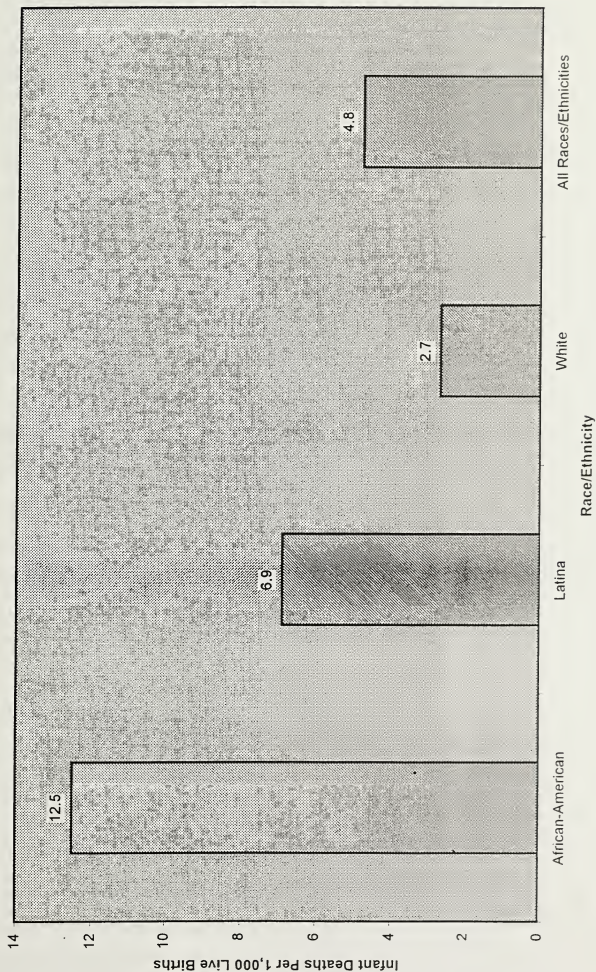
Children and Youth In Foster Care, Ages 0-18, By Race/Ethnicity, San Francisco ,1996



Incidence of Low Birthweight, by Mother's Race/Ethnicity, San Francisco, 1996



Infant Mortality Rate, By Race/Ethnicity, San Francisco, 1996



## **V. Focus Group Health Concerns and Suggestions**

### Contact List (Focus Groups)

Contact Person	Provided Referral	Interviewed	Phone Call Not Returned	Arranged Focus Group
Yvette Robinson, Director of Tenant Services, Tenderloin Neighborhood Development Corporation (TNDC)	✓			✓
Ellen Frost, Outreach Worker, TNDC	✓			
Hilda Rosomos, Social Worker, TNDC	✓	✓		✓
Margaret Gold, Treatment Coordinator Director, Jelani House	✓	✓		✓
Janet Koefler, Case Manager, Jelani House				✓
Lauri, Case Manager, Jelani House				✓
Maxine Ellis, Director, California Associate for Health Education, Employment & Dignity, Inc.	✓			✓
Tamara Mayfield, Brighter Future		✓		✓
Patricia Doyle, Director, Sojourner Truth Family, Resource		✓		
Tracy Moore, Black Infant Health Program	✓	✓		
Norma Faris-Taylor, Sistah Sistah	✓	✓		
Veronica Lightfoot, Counselor/Coordinator, Dr. George Washington Carver Elementary School	✓	✓		✓
Maybel Auyang, Parent Ed. ESL, City College of San Francisco	✓			✓
Ms. Alvara, Edgewood Family Center	✓			
Wilda, Edgewood Family Center	✓			
Nancy Frappier, MCH Advisory Board		✓		✓
Lavana Martin, Account Director, Homeless Prenatal Program		✓		✓
Salvador, Executive Director, Hamilton Family Center	✓			✓
Julie Nicholson, Counselor, Hamilton Family Center		✓		✓
Martha Ryan, Executive Director, Homeless Women Prenatal Clinic			✓	
Mai Mai Ho, Director, Asian Prenatal	✓			
Norman Yee, Executive Director, Wu Yee	✓			
Pauline Choi, Assistant Director, Wu Yee	✓			
Maryanne O'Halloran, Interim Director, Wu Yee	✓			
Dana Van Gorder, Depart of Public Health, Lesbian and Gay Health Coordinator			✓	
Kate Morrico-Klein, Coordinator of Lesbian & Gay Health Services			✓	
Dr. Kest, The Center for Special Problems Lesbian and Gay Health Services			✓	
Brian Chu, Executive Director, Lavender Youth Recreation & Information Center (LYRIC)			✓	

### Contact List (Focus Groups)

Contact Person	Provided Referral	Interviewed	Phone Call Not Returned	Arranged Focus Group
Lena Turner, Outreach Coordinator, LYRIC			✓	
Beverly Rasheed, Director, Booker T. Washington Community Center	✓	✓	✓	
Barbara, Admin. Assistant, Booker T. Washington Community Center	✓			
Cynthia K. Selmar	✓	✓		
Marsha Peerlstein, Director, Gay and Lesbian Resource Center	✓			✓
Kristopher ____, Counselor, Transgender Parents Group		✓		
Tiffany Johnson, California Youth Connection				✓
Judith Levine, MCH Advisory	✓	✓		
Dr. Francisco Ramos-Gomez, M.D., MCH Advisory Board		✓		
Ann Shine, Director, Visitacion Valley Family Resource Center	✓			
Arlene Hilton, Independent Living Skills Director, California Youth Connection	✓	✓		✓
Pamela E. Brett, MCAH Social Worker	✓	✓		
Harry Coren, M.D., MCH Advisory Board				
Illana Hettena, MCH Advisory Board		✓		✓
Michelle Rutherford, MCH Advisory Board	✓			
Linda Boseley, FIMR/SIDS MCAH		✓		
Margaret Brodtkin, Exec. Director, Coleman Advocates			✓	
Dr. Jimmy Gillard, Dept. of Social Services			✓	
Robert Uhrle, Exec. Director, Somoan Cultural Center		✓		
Alfreda Nesbitt, Program Director, Substance Abuse Program, Bayview			✓	
Novella, Admin. Assistant Bayview Hunters Point Foundation	✓			
Rosa, Director, Mujeres Unidas y Activas	✓	✓		✓
Lisa Moore, Northern CA Coalition for Immigrant Rights				✓
Rosa Pascual, Case Manager, Central American Resource Center		✓		
Bill Larkin, Director, Good Samaritan Resource Center	✓	✓		✓
Hector Melendez, Family Services, Good Samaritan FRC		✓		✓
Megan Schwartz, Medical Intern, Good Samaritan FRC				✓

### Contact List (Focus Groups)

Natalie Lopes, Director, The Family School and Resource Center				
Contact Person	Provided Referral	Interviewed	Phone Call Not Returned	Arranged Focus Group
Pat Sherman, Afrocentric Parenting Program, Glide Memorial Church		✓		
Jenean, Glide Memorial Church	✓			
Grace Webster, IRIS Center				
Lark Thomas, TAPP	✓	✓		✓
Brian Patton, TAPP, Together Taking Care of Business			✓	
Midge Wilson, Director, The Bay Area Women & Children Center			✓	
Susan Kim, California Youth Commission	✓	✓		✓
Larry Evans, From Start to Finish, Jelani House Pepe Mano, Case Manager, Jelani House		✓		✓
Ruth Hughes, Dept. of Public Health Center for Special Problems	✓			
Hilda Mendez, Education Coordinator, Lyon - Martin Women's Health			✓	
Leonard Gordon, Exec. Director, Ella Hill Hutch Community Center			✓	

## Focus Group Introduction

**Who:** The Maternal, Child, and Adolescent Health division of the San Francisco Department of Public Health (MCAH)

**What:** Is assessing the state of health care for pregnant women, youth and families residing in San Francisco by conducting a community needs assessment

**Why:** Every four years this department of public health reviews health service to the community and identifies unmet public health needs. This information is used to plan how to provide better service over the next four years (2000 - 2004).

**What we want to know:** We want to know about your health care experiences and needs. Please tell us about:

- Services that you need but feel that you cannot get
- Public health services that are not doing what you think they should be doing
- Trouble you have getting service
- What you like or don't like - what works and what does not
- How the Department of Public Health can better serve you

**Method:** Community Assessment Research and Evaluation, Inc. (CARE) will be conducting this focus group for MCAH. We will listen to your comments regarding the issues and needs that are affecting the health of this community's children, youth and families.

We will:

- not identify participant's names
- record your comments on paper and tape
- share information that has been gathered from health department resources about the health of San Francisco's children
- report our summary findings to MCAH, Department of Public Health.

*Thank you for your participation in this important work of helping San Francisco's public health care system be the best that it can be.*

f a c s i m i l e

facsimile to: Maybel Auyang, Parent Ed. ESL  
Child and Families Studies  
City College of San Francisco  
415-561-1921(officé)  
415-561-1865 (fax)

from: Karen Gilbert  
CARE  
415-437-2463  
415-437-2412 (fax)

pages: 2 including this cover sheet

MEMO: These are the general questions that we will be asking participants.  
More direct questions will surface as they illuminate issues for us.

January 22, 1999

Susan Kim  
Director  
San Francisco Youth Commission  
401 Van Ness Avenue  
San Francisco, CA 94102

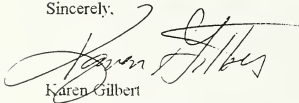
Dear Ms. Kim:

This is a follow-up letter to our conversation. I am providing the following description of our work in hopes that you will lend your assistance in accomplishing our objective of giving youth an opportunity to comment on health care in San Francisco.

The Maternal Child and Adolescent Health Department (MCH) of San Francisco's Department of Public Health is developing its four year health plan as mandated by the State of California. MCH has asked Community Assessment Research and Evaluation, Inc. (CARE) to assist it in conducting community needs assessments throughout San Francisco.

CARE would like your assistance in providing an opportunity for the voices of the youth community to be heard on the issue of care health access. We would like to arrange a focus group of approximately 10 youth who would be willing to share their opinions and experiences relative to this population's health care needs. Please contact me at (415) 437-2463 if you have additional questions.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Karen Gilbert', with a large, sweeping flourish extending from the end of the name.

Karen Gilbert  
Research Consultant  
C.A.R.E.

## **Parents of Children with Disabilities & Special Health Care Needs**

Please join us for a Health Care Focus Group

Your voice **can** make a difference.

Who's listening: S.F. Maternal & Child Health Department

When: Thursday, February 18, 1999  
6 – 8:30 PM

Where: The Center  
300 Seneca Ave.  
San Francisco

### **FOCUS GROUP TOPIC:**

What works and what are the challenges, in San Francisco,  
regarding health care access for children and families with special needs.

- ◆ Join us for a pizza party.
- ◆ Childcare provided **with advance reservation, only.**
- ◆ San Francisco residents, only.
- ◆ Eligible participants will receive a \$25 stipend.

**To confirm your attendance, and to reserve childcare, please call  
Ilana Hettner @ 469-4518.**

**SPACE LIMITED ! Please respond before February 15!**

# January 1999

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 New Year's Day	2
3	4	5	6	7	8	9
10	11	12	13 4:10p Brighter Future Focus Group	14	15	16
17	18 Martin Luther King, Jr. Day (observed)	19	20	21	22 1:00p TAPP Focus Group	23
24	25	26	27 5:00p California Youth Connection Focus Group	28 2:30p Jelani House Focus Group	29	30
31						

# February 1999

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 5:15p San Francisco Youth Commission Focus Group	2 <i>Valentine's Day</i> 10:20a Mujeres Focus Group	3 6:00p Visitation Valley Family Child Care	4 1:10p Jelani House Men's Group Focus Group 5:30p Hamilton Homeless Center Focus Group	5	6
7	8	9 4:00p Asthma Focus Group 6:00p Good Samaritan Focus Group	10	11	12 <i>Lincoln's Birthday</i>	13
14 <i>Valentine's Day</i>	15 <i>President's Day</i>	16	17 <i>Ash Wednesday</i>	18 1:00p Tenderloin Neighborhood Development Corporation Focus Group	19	20
21	22 <i>Washington's Birthday</i>	23 1:00p Homeless Prenatal Focus Group	24	25	26	27
28						

# MCH Focus Groups

Date	Focus Group	Address	Location Population	Neighborhood Population	Time
1-13-99	Brighter Future	2401 Keith Street, San Francisco	Bayview Hunter's Point	Bayview Hunter's Point	4:10pm - 6:15pm
1-22-99	TAPP	2730 Bryant Street, San Francisco	Mission District	Throughout San Francisco	1:00pm - 2:05pm
1-27-99	California Youth Connection	170 Otis Street, San Francisco	South of Market	Throughout San Francisco	5:00pm - 7:00pm
1-28-99	Jelani House	1601 Quesada, San Francisco	Bayview Hunter's Point	Throughout San Francisco	2:30pm - 4:00pm
2-1-99	San Francisco Youth Commission	City Hall, San Francisco	North of Market	Throughout San Francisco	5:15pm - 6:00pm
2-2-99	Mujeres	San Francisco			10:00am - 2:20pm
2-3-99	Visitation Valley Family Childcare	325 Neelan Ave., San Francisco	Visitation Valley	Throughout San Francisco	6:00pm - 7:50pm
2-4-99	Jelani House Men's Group	Quesada, San Francisco	Bayview Hunter's Point		
2-4-99	Hamilton Homeless Center	1525 Waller Street, San Francisco	Haight Ashbury	Throughout San Francisco	5:30pm - 6:20pm
2-9-99	Asthma	2401 Keith Street, San Francisco	Bayview Hunter's Point	Bayview Hunter's Point	4:00pm - 5:00pm
2-9-99	Good Samaritan	1294 Potrero Ave., San Francisco	Mission District	Mission District	6:00pm - 8:00pm
*2-11-99					
2-18-99	Tenderloin Neighborhood Development Corporation	217 Eddy Street, San Francisco	Tenderloin	Tenderloin	1:00pm - 3:30pm
2-18-99	Support for Families with Disabilities	300 Seneca Ave., San Francisco	Ingleside		6:00pm - 8:30pm
2-23-99	Homeless Prenatal	995 Market Street, San Francisco	South of Market	South of Market	1:00pm - 2:10pm

Youth/Adolescence

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Confidentiality</i>	Youth between the ages of 15 through 20 years of age expressed three major areas of concern relative to their health care: confidentiality; convenience of scheduling; and access to information regarding available free services. Teens wanted the option of receiving health care without involving their parents or guardians.	<ul style="list-style-type: none"> <li>Outreach methods of distributing information on the street</li> </ul>
<i>Free Service</i>	Consequently, information about services not requiring a fee or insurance coverage was desired.	<ul style="list-style-type: none"> <li>Materials should reflect the images and language of the youth culture</li> </ul>
<i>Convenient Scheduling</i>	<p>Direct street outreach using flyers or hand-outs, was the method identified as most effective in communicating with teens. They offered the proviso that the literature clearly indicate who was sponsoring or providing the services and that images of youth be visible on the materials. Another positive addition would be if the language used in the flyers was reflective of the youth culture.</p> <p>Ultimately, use of the services being promoted depends greatly on when they are offered. Teens emphasized the fact that the bulk of their day is spent in school and that their afternoons are often filled with jobs or other activities. Therefore, they preferred late afternoon and early evening clinic hours as being more compatible with their lifestyles. Once schedules are established, maintenance of these service hours is important given the strong word-of-mouth communications system that youth identified as the principal way that they receive information.</p> <p>Adolescents consistently pointed to personal choice as the critical factor determining whether a teen "gets into trouble" that leads to unwanted pregnancy, drugs, criminality, or death. They were reluctant to place blame on external or environmental circumstances such as poverty, racism, or single parent households. Rather, they framed it as an issue of low self esteem. However, they did point to a lack of recreational activities (especially sports programs for girls) and recreational centers for socializing as factors, that if available, might influence teens to choose more positive, healthy directions. There were also requests for self-esteem building classes.</p>	<ul style="list-style-type: none"> <li>Extend clinic hours to late afternoon/evening</li> <li>Provide more recreational activities and recreational centers for socializing</li> <li>Offer self-esteem building classes</li> </ul>

**Emancipated Youth**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Loss or reduced medical coverage</i>	Maintenance of medical coverage after the transition from guardianship, was the primary health care access issue of emancipated youth. For those young people who did not have health insurance coverage through their employment, the uncertainty about limitations and loss of available coverage for check-ups, surgeries, medication, as well as, dental bridges, braces or retainers, created fear.	<ul style="list-style-type: none"> <li>▪ A better system of informing youth of their rights and of methods of redressing health care complaints</li> </ul>
<i>Unresponsive social workers</i>	These fears were not allayed by the youths' assigned social workers. Rather, the young men and women complained that too often social workers failed to return calls despite numerous telephone messages requesting information. They wanted a better system of informing them of their rights and of methods of redressing health care complaints.	
<i>Voluminous paperwork</i>	Two other aspects of the health care structure were described as onerous: the volume of paperwork associated with obtaining services and the need to go to dual locations for authorization and service. Youth complained that in order to receive care through public assistance programs, they were forced to complete tremendous amounts of forms with their eligibility officer, then travel to a different facility to obtain treatment. The cost of time and dollars in transportation sometimes resulted in missed appointments. One youth who was facing the menacing threats of a bill collector, who suggested he would ruin her credit if she did not pay delinquent medical bills, found her eligibility officer unresponsive about supplying exonerating paperwork.	<ul style="list-style-type: none"> <li>▪ Co-location of health provider services and eligibility officer</li> </ul>
<i>Dual locations for establishing eligibility and treatment</i>		
<i>Stress management</i>	Stress was identified as a constant factor in the lives of these youth. One young man explained that he chose recreational use of illegal drugs as a relaxation technique when handling the lack of support at home. However, collectively the group wanted their community to provide more activities such as after school sports. They felt that increased activities, mentoring programs, educational classes on birth control options, and life skill trainings that "keep it real" and offer opportunities for youth to "check-in" or discuss what is happening in their lives, would help to reduce or manage stress.	<ul style="list-style-type: none"> <li>▪ More recreational activities, mentoring programs, life skills training, and self-esteem building classes</li> </ul>

**Emancipated Youth continued**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Teen Pregnancy</i>	<p>In discussing San Francisco's goal to reduce teen pregnancies, the youth felt that Planned Parenthood and other resources for teens would benefit by conducting a more extensive promotional effort within the schools, as well as, on billboards and the radio. As many teen girls are focused on controlling their weight and staying thin, the teens felt advertisements that emphasized the weight gain associated with pregnancy would counter the trend among some teens to want to become pregnant at an early age. They believed that schools could be more effective in preventing teen pregnancies by adopting the requirement that students obtain child care experience by taking care of "fake babies" or dolls. Additionally, they wanted to have discussion sessions run by teens parents. Finally, self-esteem building classes were desired to address the need of some girls to get pregnant in order to have someone in their lives who loves them or something in their lives that they control.</p>	<ul style="list-style-type: none"> <li>More extensive advertising of services in school, on billboards and on the radio</li> <li>Child care classes used as a disincentive to becoming a teen parent</li> </ul>
<i>Hotlines/help-lines</i>	<p>Most teens suggested that they did not use hotlines as a viable method of coping with stress. (Noted exceptions were gay and lesbian youth.) The majority of teens felt that hotlines failed to offer the intimacy and trust they required before sharing their personal issues. For them, the possibility that the person on the other end of the telephone might be laughing at them or later joking with others about their situation was disturbing. Those teens who had used hotlines in the past wanted it known that they were frustrated by staff who choose to ask the caller questions rather than simply listen and allow the caller to talk.</p>	<ul style="list-style-type: none"> <li>Hotlines or help-lines that listen versus questioning the caller</li> </ul>

Paroled Men in Recovery

Issues	Comments	Suggestions
<p><i>Insufficiencies of the parole system</i></p> <p><i>Lack of adequate employment</i></p> <p><i>Employment hindered by poor health care</i></p>	<p>Transitioning from incarceration to life as a paroled convict, focused this group of men on the insufficiency of resources afforded in the parole system and the substantial challenges of securing adequate employment. They believed that both factors negatively affected the standard of health care that they received. It was their experience that the Parole Department's pre-release classes suggested that certain health care resources would be available, but which later were found not to be. They questioned the concept of being a ward of the state but not receiving insurance and the disparity caused by parole officers who informed some men of free services but not others.</p> <p>The men were unclear as to where they might be able to obtain free glasses if they had impaired vision or treatment if they were diagnosed with Hepatitis C. They were frustrated by dental care that pulled teeth without fee, but did not provide for tooth replacement. They made the connection between all of these deficiencies and their inability to find gainful employment by explaining that the limitations on health care affected their overall appearance, thereby rendering them undesirable candidates for jobs. As one man stated, "Try going to a job interview when don't have teeth." It was suggested that these health care limitations and the fact that parolees are given no more than a \$200 stipend to rebuild their life, causes them to believe that there is a supposition that they will fail. They fear the parole process is no more than "a game." In point of fact, they described a situation in which a paroled individual who fails to pay for certain medical services received would not be released from parole or held hostage because of medical needs.</p> <p>For these men, improvements in health care access would include free bus passes to clinics; free facilities for work-out or exercise as a way of relieving stress; and faster reporting of free clinic test results (down from 3 ½ weeks) in order to reduce patient anxiety. As men in recovery, they valued the needle exchange programs and free condom give-a-ways. However, the areas they felt most in need of improvement were the homeless shelters in which most of them had spent some time. The men felt that San Francisco's homeless</p>	<ul style="list-style-type: none"> <li>▪ More subsidized health care upon release from prison</li> <li>▪ More accurate description of available free health care resources and the facilities providing service</li> <li>▪ Dental care should include replacement of extracted teeth</li> <li>▪ Transportation vouchers or bus passes to clinics</li> <li>▪ Free exercise facilities</li> </ul>

### Paroled Men in Recovery continued

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Unsanitary homeless shelters</i>	shelters are health hazards. They attribute the overcrowding at the facilities to reduced General Assistance benefits but it is there contention that much can be done to improve sanitation. These occasional shelter residents would like to see de-licing showers a mandatory prerequisite for shelter guests. Residents should be organized into work crews that maintain sanitary port-a-potties and operate washers and dryers to assure residents' clothes are cleaned. There should be on-site medical care and a scheduled transport maintained between shelter facilities and the county hospital. Women residents should be provided birth control options. Finally, health care workers should take the opportunity to educate their audience by offering workshops such as accessing the temporary job market and offering incentives for participation. It was their estimation that at least 15% of the people who come to shelters are not habitual residents, but the unhealthy environment pushes them from marginal to habitual.	<ul style="list-style-type: none"> <li>▪ Establishing procedures for the sanitary operation of homeless shelters</li> <li>▪ Transportation provided between homeless shelters and hospitals</li> <li>▪ On site education of homeless shelter residents</li> </ul>
<i>Life skills training in schools</i>	Reflecting on their school experience the men suggested that schools should do more to help youth by providing life skills training in the area of parenting classes, marriage/relationship counseling, and anger management classes. They felt schools and parents should spend equal time explaining to youth about the ravages of legal drugs (alcohol), as well as, illegal drugs. They felt that this "dose of reality" might make a difference in a child's life.	<ul style="list-style-type: none"> <li>▪ Use schools to educate youth on life skills issues</li> </ul>

Homeless Families

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Transportation expense of getting access to health care</i>	The residents of a homeless family shelter had few criticisms of the medical care they received from county clinics and health care providers. (Although they did note that if you had a substance abuse problem, you were likely to receive care more rapidly.) Their major concern centered on the challenges of getting to these facilities. Cost of transportation was a primary concern. They wanted public agencies to make taxi vouchers more available. Being able to get to hospitals at night when buses may have a more irregular schedule and the likelihood of crime increased had proven challenging for residents in the past. Some had learned a difficult lesson about relying on emergency transport services who then submitted costly bills of \$300.00 for payment.	<ul style="list-style-type: none"> <li>▪ Taxi vouchers to health care facilities</li> </ul>
<i>Insufficient dental coverage</i>	Though medical care was experienced as good, dental care was determined deficient. This homeless population expressed anger over the fact that replacement of teeth after extraction, was considered a cosmetic treatment not reimbursable according to their subsidized coverage. They pointed to the deleterious effect on oral health that can be caused by failure to replace teeth.	<ul style="list-style-type: none"> <li>▪ Dental coverage to include replacement of extracted teeth</li> </ul>
<i>Dietary restrictions</i>	The group did not feel that they suffered from lack of food or poor nutrition. However, it was explained that people on restrictive diets due to health issues do face more severe challenges of managing their dietary requirements. One example of this, was the case of a woman with low blood sugar who needed to eat frequent small meals but who was resigned to follow the regimental feeding schedule of the center.	<ul style="list-style-type: none"> <li>▪ Accommodations for individuals with restrictive diets</li> </ul>
<i>Enrichment for children</i>	Everyone agreed that homeless shelters lacked sufficient activities for children. They wanted creative activities for their children, like art projects to keep children entertained. Parents felt they needed this assistance with their children in order to have time to work through their adult problems and stresses.	<ul style="list-style-type: none"> <li>▪ Activities for children in homeless centers</li> </ul>

Homeless, Pregnant Women

Issues	Comments	Suggestions
<i>Judgmental, non-supportive behavior</i>	<p>These women felt that judgmental assumptions made by attending medical staff negatively affected the quality of service that they received and added to their level of anxiety or stress. They believed that many doctors, especially males, were not supportive of their pregnancy and caused them to feel as though they should not be pregnant. Nurse practitioners were viewed as more supportive. Evenso, female patients were at times made to feel as though they were an undesirable element "stinking up the office" because of their soiled clothing or disheveled appearance.</p>	
<i>Insensitivity and disregard for patient assessments</i>	<p>Homeless women reported that these attitudes influenced the quality of service that they received. Their collective experience was that medical staff were less willing to listen to patient comments about their own state of health or medical condition. Health professionals failed to chart patient comments into medical records. Staff hastily dispensed with medical problems, prescribing medication instead of counseling or narrowly limiting examinations by excluding some patient concerns. In an extreme case, one women hospitalized for symptoms of premature labor was given drugs to arrest labor and then discharged despite her warnings to staff that she believed she was on the verge of delivery. While staff left the room to attend to discharge paperwork, the patient literally delivered her baby with the help of a friend who had come to escort her from the hospital. In general, homeless, pregnant women felt that their interaction with the health care system left them feeling "belittled."</p>	<ul style="list-style-type: none"> <li>▪ Prescribing counseling may be just as important as prescribing medication</li> <li>▪ Consider all of patient's concerns</li> </ul>
<i>Lack of family and friend support systems</i>	<p>These women believed that by doctors developing a greater level of sensitivity and understanding of patient needs, the public health care system could be improved. They would like medical staff to embrace the concept that health care is a team effort and patients are part of the team. Given that homeless people often do not have friends and family who can act as support systems for them, the women thought it would be valuable to have advocates who can promote their needs, particularly during the brief, five minute clinic examinations. Finally, they would like the medical profession to be as supportive when they are not promoting concepts (like breastfeeding) as they are</p>	<ul style="list-style-type: none"> <li>▪ Team effort approach toward health care</li> <li>▪ Assign advocates to make certain women's needs are being met</li> </ul>

Homeless, Pregnant Women continued

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Insufficient postnatal care</i>	<p>when attempting to encourage behavior. Women noted that after their child's birth, if they chose to breastfeed, they would be offered a greater level of follow-up care than when formula feeding was elected. Women did not feel that the election of one method over the other should diminish the amount of postnatal care they were afforded. They also wanted an information hotline that provided new mothers and young mothers with infant care information. These services complemented by an increased offering of free health pamphlets on diseases such as diabetes and lupus (versus the omnipresent HIV/AIDS booklets) would allow women to make better use of the lengthy waiting periods that precede clinic appointments.</p>	<ul style="list-style-type: none"><li>▪ Greater postnatal care for infants and mothers</li><li>▪ An information hotline for mothers</li></ul>

**Immigrants**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<p><i>Language barriers</i></p> <p><i>Limited knowledge of available resources</i></p> <p><i>Limited access to health care information</i></p> <p><i>Fear of reprisals</i></p>	<p>Language barriers, limited knowledge of available health care resources, and fear of jeopardizing pending citizenship applications or revealing illegal status diminished the quality of care the immigrant population received. They experienced long waits before appointments could be scheduled with bilingual doctors, only to find that the doctor's fluency in the desired language was severely limited. Incidences were described of translators/interpreters disregarding patient requests. Even completion of forms often proved too challenging due to the necessity of medical terminology. This difficulty often arose when providing medical histories or following medication instructions. One woman described her feeling of inadequacy associated with trying to decipher English only asthma management instructions, by looking at the pictures. The group explained that often a clinic's supply of bilingual instructional information would be depleted. Their suggestion was for the public health department to train community people to do outreach. These individuals would be able to access the community in non-threatening environments such as, laundromats, bus stops, and grocery stores, answering general questions and making referrals.</p> <p>Social workers sometimes served as the only resource the interviewed immigrant population used to obtain information about free services or programs. Yet, the work volume of the social workers compromised this information. Frequently, telephone calls were not returned or rushed counselors would pressure clients into choosing options they really did not understand. The group thought this system of information would be improved through supplemental training of social workers. They would like to see "good social workers," (i.e., attentive, informed, and courteous) used to train the others in order to eliminate the disparity in levels of service rendered.</p> <p>Having the system correct itself, was an important concept for the immigrant population because many expressed fear of complaining to authorities. They did not want to jeopardize any way their ability to remain in this country. For this reason, they expressed a preference for sliding fee scales rather than free</p>	<ul style="list-style-type: none"> <li>▪ Train community people to do outreach</li> <li>▪ Use model social service staff to train their peers</li> <li>▪ More sliding fee scales</li> </ul>

**Immigrants continued**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Lack of affordable care</i>	services requiring extensive paperwork. They explained that it was sometimes difficult to obtain necessary pay stub documentation from employers in order to meet salary verification requirements. Many felt frustrated and penalized by a public health system that provided no affordable health care coverage for their families simply because they chose to work 2 to 3 jobs causing them earn salaries slightly above the recognized poverty line. They also wanted information on the rights of illegal aliens to health care.	<ul style="list-style-type: none"><li>▪ Affordable health care for the working poor</li><li>▪ Information on the health care rights of illegal aliens</li></ul>

**Parents of Children with Special Needs**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Prejudice</i>	Parents of children with special needs, whether physical, mental or emotional, described prejudice as one of the first hurdles they must overcome in order to obtain adequate health care for their children. Many professionals such as dentists or optometrist choose not to serve children with certain disabilities. Their decisions may be based on insufficient training to handle special needs clients or simply lack of desire, but the effect is the same – a very limited pool of resources for families to use. Parents say that they are forced to travel long distances and endure lengthy periods between appointment scheduling and medical visits in order to have their children's health needs addressed. Additionally, parents experienced a sense of annoyance and a lack of understanding on the part of waiting room staff at medical facilities. Often, staff become visibly irritated by the behaviors of some special needs children who find it difficult to wait long periods for service, in noisy environments. Just as priority scheduling is afforded to infants at some medical facilities, parents believe that giving special needs children in waiting rooms similar visitation priority would help in relieving some of the waiting room tensions, in the short-term. Another aid would be a resource guide so that families can pool their knowledge of available resources. As a long-term solution, parents would like to see better training of medical professionals.	<ul style="list-style-type: none"> <li>▪ Reducing waiting room time for special needs children by calling them first</li> <li>▪ Funding a parent-developed resource guide</li> <li>▪ Better training of medical staff</li> </ul>
<i>Limited resource pool of knowledgeable professionals</i>		
<i>Insensitive medical staff</i>		
<i>Adversarial relationships</i>	The very nature of their children's disabilities forces these parents' concurrent involvement in many systems (medical, social service, educational, etc.). In concept, these systems are designed to help the child, but parents often find the relationship to be antagonistic or adversarial. It is their experience that agencies with the responsibility of diagnosing the child, shy away from dual diagnosis of need. Rather, there seems to be a tendency to limit the diagnosis in order to limit the resources that will have to be expended for treatment. Case managers lack information about available services, relying heavily on parents to identify resources. Educational institutions have appeared slow to recognize developmental or learning disabilities in children, allowing them to suffer long periods of poor performance before taking corrective measures. In	

Parents of Children with Special Needs continued

Issues	Comments	Suggestions
<p><i>Non-inclusion in teen health statistics</i></p>	<p>what parents described as a “power struggle,” doctors or specialists appear to discount parents’ knowledge of their children when making assessments and prescribing treatments. In defense of their children, parents requested the funding of advocacy agencies to assist them in maneuvering system barriers to adequate health care. The relationship with case managing agencies has become so strained that these parents do not trust staff to act in the best interest of their children. In fact, they felt that it has become the culture of the agency to “hoard” resources by acting as “gatekeepers”. They did not feel confident that change would occur in the absence of parent supported advocacy groups or organizations; and they wanted to see county dollars directed toward the support of these entities. They believed that overall relationships would improve when parents of children with disabilities and appropriately aged youth with special needs, begin to sit on more advisory or community boards.</p> <p>Finally, these parents indicated a desire for the public health department to begin reporting health statistics on special needs youth. They feel that the special needs child faces many challenges and stresses that place him or her at risk of negative behaviors such as substance abuse, teen pregnancy, and suicide. Yet, it has not been the practice of public agencies to report the frequency of these occurrences as it relates to this segment of the teen population. Parents believe acknowledgement of the problem is the first step in addressing it.</p>	<ul style="list-style-type: none"> <li>▪ Advocacy organizations selected by parents and funded with government dollars.</li> <li>▪ Parents appointed to advisory or community boards.</li> <li>▪ Begin collecting and reporting statistics on special needs children, especially adolescents</li> </ul>

**Bayview/Hunter's Point Community**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>No major health care facility</i>	Within the City of San Francisco, Bayview/Hunter's Point represents a district besieged by many negative health indicators. The predominantly African-American community expressed concern over the absence of a major health care facility located in their neighborhood. They believe that such a facility is warranted given statistical indicators highlighting low birthweight infants, teen pregnancies, and communicable diseases. They feel the presence of super fund sites and toxic soil areas, as well as, identification of cancer and asthma clusters, buttress their argument.	<ul style="list-style-type: none"> <li>▪ Provide a major health care facility (hospital) in the district</li> </ul>
<i>High asthma levels in the population</i>	School staff are concerned about the large number of Bayview/Hunter's Point students who have been diagnosed with asthma. They note that some children seem to lack proper instruction in how to manage their illness. The residents would like the source of the illness investigated.	<ul style="list-style-type: none"> <li>▪ Identification of environmental causes of asthma and instruction in asthma management</li> </ul>
<i>Corrective measures not provided for children</i>	Equally frustrating to administrators are school lists of students who remain without corrective lens, despite in-school vision tests that uncovered their need. Taking time off from their jobs appears to be a major impediment for some of the parents of these children. School staff commented that frequently parental work schedules cause families to delegate breakfast selection and preparation to the eldest child in the home. For this reason, school counselors more nutrition education for children would be valuable.	<ul style="list-style-type: none"> <li>▪ Increased nutritional education for children</li> </ul>
<i>Information void relative to sex education</i>	Adults in the community felt public agencies like schools or the public health department should fill the information void surrounding some children on the subject of sex education. They did not want to see these children make mistakes due to some parental failure to educate their children. However, the parents suggested that sex education emphasize the consequences of certain behaviors such as using pictures to depict what sexually transmitted disease looks like on the human body. Their hope was that this dose of reality would serve as a deterrent.	<ul style="list-style-type: none"> <li>▪ Providing sex education emphasizing consequences</li> </ul>
	Youth in the community complained of high levels of stress. However, they did not feel comfortable sharing	

Bayview/Hunter's Point Community continued

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Adolescent stress</i>	these issues with medical professionals or help-line counselors. Nor was their much opportunity for male adolescents to share their feelings with friends. They explained that "you just don't do it." Evidently, no one wants to befriend you if you are lamenting your problems. They have adopted the motto, "handle your business" to express the solitary nature of being responsible for your own affairs. Unfortunately, many youth described friends who were not successful living by this creed without the help of drugs, crime or unhealthy relationships. Teens felt that they would feel better about using a help-line if it were staffed by someone from the community who they respected.	<ul style="list-style-type: none"> <li>▪ Help-lines staffed by respected community members</li> </ul>
<i>Lack of recreational activities</i>	Young women suggested that the motivation for some of their friends to become teen mothers has been their desire to have someone who loves them and someone they can control. Those girls who had resisted this temptation believed that having more recreational activities for teens would be one way to combat this tendency. Also, self-esteem classes were viewed as valuable.	<ul style="list-style-type: none"> <li>▪ More recreational activities (for girls)</li> <li>▪ Self-esteem classes</li> </ul>
<i>Inconveniences of medical care for pregnant teens</i>	Pregnant teens interviewed felt they were receiving good medical care. However, they did state their dissatisfaction with having to receive prenatal care at a different facility from where they would give birth. They were displeased with medical staff who would not allow them to keep the sonogram images of their babies or with nurses who had failed to explained to them how to take care of stretch marks. They were less comfortable with male doctors and questioned why hospital baby pictures were so expensive.	<ul style="list-style-type: none"> <li>▪ Co-location of prenatal and delivery services</li> </ul>
<i>Affordable housing</i>	Most pregnant teens did not anticipate problems in the postnatal care of their children. They felt that their parents would provide sufficient help when the baby first arrived home. Those who were not planning to live at home, feared that finding adequate and affordable housing in San Francisco's expensive rental market, might affect the quality of overall care that they provided their child. Most were looking for shared housing arrangements in order to survive.	<ul style="list-style-type: none"> <li>▪ Affordable, safe housing</li> </ul>

**Tenderloin Community**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>Negative image of the Tenderloin</i>	Residents of the Tenderloin want to change non-residents' perception of their home. They feel people do not understand that this is a community of families, despite the visible homelessness and street crime. Comments were made that police intensify the problems of the area by treating it as a containment area, dropping off a constant stream of parolees onto their streets. They fear that until policymakers view the Tenderloin as a family community, their community will suffer from lack of important resources like recreational facilities for youth; health care facilities for the general public; and appropriate policing that allows people to safely walk in the neighborhood with their children.	<ul style="list-style-type: none"> <li>Want community to be provided with the basic needs of a "family community"</li> </ul>
<i>Toxic environment caused by vehicle emissions and lead-based paints</i>	Many described the general environment as toxic, caused by vehicle emissions from the high volume of car and bus traffic. They pointed to apartment windowsills and drapes that show heavy signs of dirt accumulation and discoloration. Families were equally concerned about the hazards of lead poisoning given the older ages of some of the buildings in the Tenderloin. They felt that there should be a task force on the "ills of the community," including what they called the dumping of parolees into their neighborhood by police.	<ul style="list-style-type: none"> <li>Call for a task force to discuss problems in the Tenderloin</li> </ul>
<i>Mental health issues</i>	Mental health issues were also a concern of the community. They believe many of the individuals arrested for criminal activity are really people suffering from forms of mental incapacity. Instead of receiving treatment, these people are allowed to become violent and then are arrested. It was suggested that there should be more outreach to these individuals. Residents envisioned mobile units of psychiatric and counseling professionals who could administer to the needs of people on the street. They felt it should not be so difficult to find dual diagnosis help for the mentally disturbed.	<ul style="list-style-type: none"> <li>Greater outreach to mentally disturbed through use of mobile units</li> </ul>
<i>Lack of sufficient health care</i>	Adults described their public assistance health care coverage as insufficient, often saying it "falls short" of what they need. Residents complained of inability to afford replacement teeth after extraction dentistry. Some men used emergency room treatment to manage	

**Tenderloin Community continued**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<p data-bbox="125 216 249 340"><i>Information on health care resources unavailable</i></p> <p data-bbox="125 738 249 861"><i>Nutritional deficiency, hunger and homelessness</i></p>	<p data-bbox="267 216 759 614">their health care needs. It was the collective belief of the group that information on where to find health care resources is not readily available. Many people do not know where to seek help. Grandparents who were not legal guardians but who shared responsibility for their grandchildren wanted to know where they could go to get information on grandparent's rights. Few people were aware of help-line/hotline numbers that could direct them to needed services. In general, they felt there was an information void. There was a request for a directory of resources. Residents wanted to have on-site family counseling and other social service counselors located in residential apartment buildings. They pointed to the on-site counselors available at some of the Tenderloin Neighborhood Development Center properties as positive examples.</p> <p data-bbox="267 642 759 1033">Residents noted homelessness and hunger as two additional gaps in the health care framework of their community. They described individuals who did not have sufficient monthly income to provide themselves with food for the whole month. It was suggested that problems were compounded for some of these people because their infirmities rendered them unable to stand in long lines at soup kitchens. The community felt that the fact that these conditions were allowed to continue, was a sign of government neglect. The group wanted public health nurses to make more home visits in order to administer to the needs of this population. Additionally, Tenderloin residents wanted to see abandoned buildings opened for use by the large number of homeless people that roam their neighborhood.</p>	<ul style="list-style-type: none"> <li data-bbox="778 216 902 292">▪ Develop a resource directory</li> <li data-bbox="778 367 902 539">▪ On-site family counseling services in residential apartment buildings</li> </ul>

**Inner Mission Community**

<i>Issues</i>	<i>Comments</i>	<i>Suggestions</i>
<i>High incidence of teen pregnancy and gang violence</i>	Recorded statistics indicate that this predominantly Latino community faces some of the highest incidences of teenage pregnancy, juvenile crime, and sexually transmitted disease in the City of San Francisco. Both parents and youth are concerned about their health in light of these statistics. Parents fear for their family's safety and often prohibit their older children from going outside at night. Teens feel that stereotyping by police often leads to harassment of innocent teens. Adolescent girls declared that "you can't go out at night on Mission Street wearing a red dress without police officers harassing you." Community groups of teens and adults suggested increased recreational activity for youth as a way to turn around the negative trend of gang violence. Teens specifically requested team sports for girls, dances, mentoring programs, and career job-shadowing opportunities as deterrents to negative, unhealthy influences.	<ul style="list-style-type: none"> <li>Increased recreational activities for youth</li> <li>Mentoring of youth and career guidance</li> </ul>
<i>Culturally insensitive medical professionals</i>	When interfacing with county health facilities, the Mission residents found medical personnel to be insensitive to cultural differences. Issues such as female modesty about being disrobed or having teams of interns come in to examine your condition without requesting patient permission were points of irritation. They disliked shared examination areas in which doctors discussed individual's cases within hearing of other patients. This offended their sense of privacy. While in other situations, they felt physicians used privacy rights of adolescents to exclude parents from important matters. An example was given of two, young adolescent males' first physical examination in which the single mother was prohibited from being in the examination room. Because the doctor had not prepared the boys for the experience by explaining what the examination entailed, the boys felt that he had sexually abused them. Later the boys complained to their mother that they felt she had knowingly "betrayed" them by not protecting them from this abuse and they vowed never to go to a doctor again.	
<i>Long waits for service create hardship</i>	Community members were disappointed at the long wait for service at public health facilities despite having appointment times. They felt it was a hardship on them to have to miss such long periods from their	

Inner Mission Community continued

Issues	Comments	Suggestions
<i>Perceptions of inferior medical care</i>	<p>jobs in order to take themselves or their children for medical visits. Many complained that after waiting great lengths of time, or in the case of the uninsured, paying dearly for their health care visit, all too often public health care practitioners simply prescribed Tylenol and sent patients home. Residents perceived the Tylenol treatment as inferior care administered in order to move them quickly through an overcrowded system.</p>	<ul style="list-style-type: none"> <li>▪ Explanation of why Tylenol is frequently prescribed as the appropriate medication</li> </ul>
<i>Unlicensed vendors of street medications</i>	<p>The community group explained that many Mission residents were familiar with the practice followed in some South American countries of using pharmacies as the first point of contact in diagnosing and caring for illnesses. Pharmacists would provide the necessary medication and patients would visit doctors only if the problem persisted. In keeping with this cultural practice, and as a way to circumvent the expense and frustration of "the magic Tylenol" cure-all, some Mission residents purchase drugs such as antibiotics from street vendors located at privately known locations in the Mission. Mothers explained that they do fear not having proper instructions on how to administer drugs purchased from street vendors. However, they felt that providing their children with "more effective medication" was worth the risk.</p>	
<i>Need for first aid training</i>	<p>Adults in the community wanted more information on appropriate first aid care for children. They felt inadequate in assessing and handling the many scrapes and "fall down" injuries witnessed while children (not necessarily their own) were at play in the neighborhood. They wanted to circumvent the need of having to take a child to the hospital emergency room when minor first aid care would suffice. Additionally, they wanted to know the legal ramifications of providing first aid to neighborhood children. Residents suggested that grandmothers or other community individuals could be trained by the public health department to provide first aid consultation in these situations.</p>	<ul style="list-style-type: none"> <li>▪ Train neighborhood individuals to provide first aid consultation</li> <li>▪ Explain legal ramifications of providing care to non-family member</li> </ul>

***BRIGHTER FUTURES FOCUS GROUP 1-13-99***

- Someone from the neighborhood
- Confiding – what benefit
- Take advice – Do advice – Advice does not work do not return
- Vendor on street with condoms
- Nutrition classes
- Notify of the need for checkup (free)

**Medi-Cal: How do you apply:**

**Therapist – Stress – Depression**

- Want Therapist?
- Want Masseuse?
- Want Psychiatrist?
- Want group sessions?
- Outreach program to teens to keep busy
- Help telling parents so they be stressed out
- Confidential person to talk your problems out with
- Making decision between keeping baby & abortion

## *California Youth Connection Focus Group*

### **Time**

- You have to wait so long
- Only 2 facilities/places to go
- Takes too long

### **Medical**

- Don't cover everything

### **Limitations**

- Not full medical

### **Coverage**

- Surgeries
- Medicines

### **Dentist**

- Can't get bridge, braces or retainers
- Teeth have to be really messed up

### **Location**

- One place for approval another for service

### **Teen Pregnancy/AIDS**

- Strict parents don't talk to kids about issue
- Workshops in teenage ward at hospital & schools
- Restrictions make you want to do it more
- Have young people talk to young people
- "Fake baby" care opportunities

### **Resistance to Birth Control**

- "If you get pregnant you get fat"
- Counter advertising of being thin
- Weight gain – liver failure
- Education around birth control options

### **Self-esteem Workshops**

- Need to care about themselves

### **Advertise plan parenthood more**

- Schools, billboards, radio
- Life skills - check-in – "keep it real"

### **Youth Representative – Those with Experience**

- Panel from varied experiences

### **Privacy**

- Important to youth not to have parents have all your info

### **Hotlines**

- They ask questions; I want them to listen
- Discharged off Medi-cal at 20 years without explanation
- Pap smear – eye exam – teeth; planned parenthood covers, but not eye or dental

## *California Youth Connection Focus Group*

### **Billing**

- Eligibility officer non-responsive threats of credit collections

### **Social Worker**

- Leave 100 messages and they don't call you back
- "Information" on Medical, where to go, what to do
- Don't like UCSF – slow; too much paperwork; lots if inexperienced interns
- Redress for health complaints "knowing your rights"
- Pregnant people talking to those who aren't pregnant as a preventative

### **Drugs**

- Relaxes you; no support at home
- More activities
- After school sports
- Mentors
- Go to school ask teens what their interest is

### **Talk to teens about**

- "Deep results"
- If your outside would you smoke

*Jelani House Inc. Focus Group 01/28/99*  
*Residential Drug & Alcohol Program for Pregnant Addicted Women*

**People wait until they are in pain before they get care**

- Preventive medicine, regular check-ups, dental insurance coverage not provided.
- Knowledge of sealants and other preventative measures

**Medical**

- Difficult to find out which dentists take medical referrals have resulted in bad experience (missed cavities)

**HIV**

- Only have 1 meeting for group on schedule NA/AA (Narcotics Anonymous – Alcohol Anonymous) per week – very limited schedule prevents attendance
- Why?
- Where its located in Castro

**Go to General**

- Have to wait all day before you see doctor
- Messes up schedule
- May get better

**Prenatal**

- Didn't know she was pregnant
- Need more mobile medical unit park on 3<sup>rd</sup> street
- Park outside high school when kids are getting out.
- More education
- More support groups
- More support groups in school
- Health clinic in the school – mandatory
- Need to know location of planned parenthood

**Stress**

- Decision to keep child based on pain experienced from prior abortion – thinks poor health care caused it. Created stress.
- Abortion clinic – offered no 1 on 1 counseling for foster daughter. Need to deal with mental anguish
- Hotlines – afraid people won't call because they are afraid to have to pay. Cost to call – maybe not have \$.35 to use
- Free Walk-In Clinic – get services
- STD's – continue doing what you've been doing: (Posters, flyers, etc.) it's an individual choice

**More Information of HIV vs AIDS**

- Men – clinic experiences for men can feel more comfortable then seeking from coed issues
- Mandatory testing – likes criminal control of prostitutes who knowingly spread STD's

**Domestic Violence**

- Domestic violence classes in school/in clinic
- Stronger criminal charges (only result in misdemeanor & slip to go to classes)

**Jelani House Inc. Focus Group 01/28/99**  
**Residential Drug & Alcohol Program for Pregnant Addicted Women**

**Substance Abuse**

- Domestic violence billboards!!! Location!! of bay bridge
- If you're getting your ass whipped
- Call 1-800
- Same goes for substance abuse
- Knowledge of mom's experience
- More options for kids "after school" or "in school" (set out an hour a day) more involved in activities less likely to do drugs
- After school programs about drug use
- Cost of activities too expensive
- Combined activities for parents & children
- Community picnic

**Child Care**

- Costs too much!!
- Especially when you're in recovery (thank you dress for children's council)

**Prevention:**

**More services for teens & pre-teens**

1. Counseling
2. Scared straight
3. Teen centers
4. Educate a group of teens to go to school & tell the word – Those who have gone to jail

**Jelani House – stop reducing the length of 18 and up residential treatment programs**

**Walden House – more coed adolescent**

## *San Francisco Youth Commission Focus Group 2/1/99*

### **Health Clinics**

- In schools
- Free
- Mobile Health Centers that are less obvious (anonymous)
- Translation of documents into different languages
- Having neighborhood center distribute information
- Regular day of the week
- Have school health class notify students of mobile clinic activities
- More street outreach
- Increased confidentiality among health clinics
- Outreach in schools – addresses of health centers
- Flyers, documents developed specifically for parents
- Culturally appropriate documents
- Free information clearinghouse that is confidential
- Hotline for alternative groups that might call a hotline

Health Initiatives for Youth – 487-5777

Center for Young People Development – 487-8662 – Jessica Latifa - Director

### *Mujeres Focus Group 2/2/99*

- Be able to get treatment in a timely manner (not have to wait a month).
- Decrease waiting time. Lose a whole day of work for five minutes with doctor and can not or is not allowed to ask questions.
- Information and handouts should be in spanish if not all the time as close as possible to all the time. Doctors are described as bi-lingual but have very limited spanish.
- Be able to consistently see the same doctor.
- Cost of emergency treatment and interest charged for making payment and direct charges on credit card.
- Appropriate treatment. We receive tylenol for many treatments and it is very expensive.
- Intakes ask where patients are from and this immediately causes them to be uncomfortable.
- Fear of getting prenatal care because of political environment.
- Asking the question differently. They ask are you a resident and they could ask do you live in San Francisco.
- There has been training but more training is needed.
- More incentive to make changes more parent (adult) involvement in addition to doctor's recommendations.
- Doctors need to tell the parents and the child what they plan to do to avoid upsetting the child.
- Doctors need to have more awareness of who they are dealing with and explain what they plan to do, why they are doing it, how its going to feel, etc....
- Cultural thing. Not use to displaying parts of their body.
- More privacy. Two, three, or four other women in the same room or leave you exposed and say they will be right back or students will be included in the exam. These occurrences traumatize the patient.
- It would be good if they would ask us first before including others or students.
- No free services. Children are cut off of medical. They advertise free vaccinations but when you show up there are none for you.
- They pay bills. Then two or three years later they receive the same bill.
- Medi-cal fear. Fear of future bills. And people that are waiting on immigration status are afraid it will affect their status.
- Medi-cal income guidelines are problems. Their incomes are many times slightly over the guidelines.

## *Mujeres Focus Group 2/2/99*

- Monthly income verification causes problems because of the frequencies and the proof required. We are not always able to produce the proof they required. \_\_\_\_\_ possible verifying income once a year.
- Streamline interview about medical history. Many times we do not know. They need the information. Help with the forms may help the patients.
- Publicize origination may aid completion of paperwork.
- Reduce the size, length of application (health families).
- Stop forcing patients to sign up for programs they may qualify for but may not be the right thing for you.
- Have "all" social workers explain programs. Some can or won't explain.
- Access to social workers. Hard to get in touch with them. You only speak with them when they want to tell you, you did not send something. Do not answer. Always message machine. Attitude (you are getting free services you are undocumented). There are also good workers.
- Make outreach and advertisement non-intimidating.
- Take advantage of time when you are waiting on phone to talk to worker or waiting for worker.
- New patient desk. Job specifically for originating.
- When you call an ID of who you have called before being put on hold with music.

### *Visitation Valley Family Child Care Focus Group 2/3/99*

- Return and answer phone calls
- Shorter waiting for translator
- Serve others not just own dental patients
- When calling and able to talk, told they are full, call back in two days
- 3-6 months to get appointment
- Health clinic #3 need more translators, specifically chinese translators
- When served, they are asked to take off their clothes and put in a room for hours to wait
- Dental only serve patients up to age 17
- Charged full price but not given service comparable to private care
- Trauma center to speed up emergency room visits
- High child care/medical fees for new immigrants
- Clinics in the schools possible infringement on parent's rights – balance
- Limited confidentiality with the children for those children who may not have anyone to talk to
- Immunization – multiple shots of a period of time not on one day
- Ability to get appointments on specific days and when have appointment able to be seen at appointment
- After receiving 6 months check up over a period of time told he is in the last stages of cancer
- During stay for childbirth left in hall for two hours before being put into a room. Unauthorized person tried to draw blood
- Sex education in the schools starting in middle school – not too open – separated by gender – question by a qualified person (nurse)
- Classes for parents on how to talk to their children
- Chinese parents are more conservative: no sex before 18
- Teach them (teens) what will be the result of sex (pregnancy)
- Teach them if they have babies, they have responsibility
- Actually show the children the physical results of the sexually transmitted diseases, also would be effective with teenagers, difficult of caring for babies

*Visitation Valley Family Child Care Focus Group 2/3/99*

- Stress prevention with the children around sex
- Coordination between schools and parents
- More nurses in the schools at least one per school
- More help for special education – Department of School District
- Appropriate determination/diagnosis of a special ed. child. Some are put in special ed. for behavior
- Hot school lunches that are “hot” and an appropriate portion not too much and not too little
- Glasses not covered under health care
- Contraceptive for men (more of them)
- Slightly higher income. Does not qualify medical.

## *TAPP Mens Group Focus Group 2/4/99*

### **Dental Problems**

- They take them out but do not put them in
- Money
- Where to get treatment
- Need for employment
- Knowledge of possible programs

### **Hepatitis "C"**

- How do you find out about it

### **Vision**

- The need for glasses
- Cost
- Knowledge of insurance/coverage

### **Upon Release**

- Told that resources are available, but when you try to get services they are not available
- Should not have to wait 3 weeks to find out the results of test
- Some individuals get free services and others have to pay for the same services
- You have to get the parole officers upset before you can get served appropriately
- Asked/required to get certain services/treatment but they require the person to pay for it and won't let you off parole until paid
- Reduce drug use by mothers
- Needle exchange programs and give out condoms

### **Address homeless problem**

- Shifting them around is not working
- Told place is open and it is not or you get there and its standing room only

### **Checkout shelters**

- Treatment, conditions, and food etc...

### **Mission Rock**

- large facility (heating) 24 hours/7 days. Bed bugs (no screening) increase professionalize shower people de-bug. Washer/dryers better facilities – portables. Follow-up services people come in many times only need temporary support and because of the condition in a year the situation is just as bad as the worst

### **Pre-screen**

- people come from shelters to various other places and if infected others are put at risk (some look clean)
- education in the shelters for the people that want it

### **GA**

- Workers respond s if it is just a job. They want to get you in just to get you it. They can explain the program more tell the person what they can get out of it. For what they are doing we do not need to hear what they are saying. They talk to you crazy, there are some people who need this but should all of us be treated this way.
- Need to let us know where we can get temporary employment. There should be some type of incentive for job training

## *TAPP Mens Group Focus Group 2/4/99*

### **Birth Control Classes**

### **Communication**

#### **Hotlines**

- Not used much – some (most) think they are gimmicks – Solution – release mechanisms – Place to go to exercise, scream.

#### **Education for Children around Drugs and Violence**

- Start at earlier age (2<sup>nd</sup> grade) affects on person, society

#### **More Education for Parent around Drug Use**

- Actually see result
- More awareness about alcohol
- When someone begins to get into fights in school, then they should start attending anger control classes – part of curriculum – there is a limit it is hard to tell somethings to be fixed at a young age
- Counseling (marital and others) starting in school
- Environment – drugs/alcohol/tobacco/smog

*Hamilton Homeless Center Focus Group 2/4/99*

- 911 responded quickly and appropriately
- Dental Care – hard to find a dentist
- Replacement of teeth should not be considered cosmetic.
- Access to food
- Travel in the city is difficult
- Vouchers
- Hotlines have worked for those who have called
- Children's activities helps both the parents and children
- Parents should talk and teach children
- Some are violent without using. Some use it as an excuse for their actions

### *Good Samaritan Focus Group 2/9/99*

- What do you do as a single parent when a child becomes ill?
- What can the grandmother do or what are her rights when she takes her grandchild to the hospital?
- Information on programs that deal with children going to school and becoming sick.
- More social workers.
- Be told what has to be paid and what is covered.
- Received positive treatment. At general did not feel uncomfortable about race or lack of money.
- Can not get in contact with social worker. Possible issues: 1) work load 2) Personal or 3) they do not know what they are doing.
- Sometimes workers treatment leads to discontinue not based on qualifications.
- Being taught, as a community or neighbor, how to handle minor injuries ourselves.
- A user friendly place with many services.
- To know the rights of immigrants. Charged a lot of tylenol and treatment – had no insurance.
- More education about rights, programs, and benefits.
- Places to inform: Channel 14, Health Center (Good Samaritan) Flyers.
- Told she could setup a payment plan but was not told that if you are low-income your options are...
- A place for information, documents, translations, direction to
- Medical advisors that community will talk to that can help advise (in between professional social workers).
- A place that recommends medical answers with over-the-counter medicine.
- Open more sick clinics
- Hiring the community to help the community
- Help for single persons
- Free treatment good, after getting insurance and going for treatment, very bad treatment. Questions about daughter at hospital for 104-degree fever suggested put ice in mouth.
- Forced to go underground to get antibodies and take risks with use of the antibodies.
- Need dental care information.
- Dental waiting lists at community clinics are four months.

## *Support for Families with Disabilities Focus Group 2/18/99*

### **Prejudice**

- Toward children with disabilities
- Only diagnosis for a single diagnosis
- Toward the cause of the disability
- Training – only see extreme cases
- Barrier in getting the child 51/50
- Brochure to every parent about special education
- Decrease the time between diagnosis to treatment
- After referral the child should receive an extensive and comprehensive examination
- Every child should be in a social skills group

### **Dental**

- Could not get anyone to see her son. Soon as they were told he was autistic no one would see him. Had to take him to a specialist.
- Not enough resources tend to make parents hold on to information (not share) or be very selective about who they share with.

### **California Children Service**

- Child needs serial casting. Casting can take place because of clause that requires therapist to be on duty twenty-four hours.
- Concerned about the order in which treatment is given.
- Have to wait too long to get treatment.
- Limited to when you can call the doctor.
- No patient care concerns, none considered “just numbers”.
- Lack of trust in the care provider’s abilities.
- Lack of consideration for the parents.
- No childcare when another child is treating at treatment facility.
- Training or more training on interaction with parents (sensitivity training also)
- “Power Struggle” between the parent and the doctor that is based on the assumption of “you can possibly know more.”
- Doctor mistaken the mother for the five year old daughter. Then advised they did not have any complaints. Eventually completed a pre-printed form complaint. Did resolve and changes were put into place.
- After taking son to mental health doctor, was concerned about the lack of options and the only and first option of putting the son on medication
- Had to wait for two hours with two children to get a simple TB test.
- Training for providers around advocacy.
- Mediation training for parents.
- Anger training/management.
- Nothing for dyslexic children
- Advocacy systems are the problem. Many times these systems act as “gate keeper.”
- Case managers are not case managing they are acting as gate keepers. They do not present to the insurers. They just tell the clients what they should do.
- Among the health provider in SF there is a lack of sensitivity to the patient. They have a tendency to minimize the issues.

### **Child Crisis**

- 3 hour waiting period
- Impersonal service
- Run around with provider list
- Return to child crisis (after unable to 51/50).

## *Support for Families with Disabilities Focus Group 2/18/99*

### **California Children Services**

- Receive letter while three-day-old child was still in the hospital demanding specific documents.
- Should be someone who can relate on a kinder level.
- No families on the board (hospital) and any health care provider or access and children.
- Someone to follow up on all referrals
- Neutral system to involve the parents and paid well/appropriate unit.
- No information on diabetics
- When asked for support help always sent. Doctors, nurses, and/or therapist that does not work. What want is someone who has experience what they are going through and to whom they can relate.
- Resource book with everyone's experiences.
- Service for dual-diagnosis, asthma and autistic.
- Resources for principals and teachers at school. Parent not notified and the child allowed to sleep all day in the principal's office. Turned into a learning disability.
- School nurses in all schools.
- Parent and professional training that is combined.
- Asthma in the Bayview district. Everyone has asthma
- Children need to be educated by someone relating to them. Children need to be challenged.
- "Family Life Education" sexual education for children.
- Tenderloin – no clinics, no children mental health clinics, no teen clinics.
- Something other than hilltop for pregnant teens
- Mentor program for pregnant teens
- Haight ashbury – homeless problem

**Tenderloin Neighborhood Development Corporation  
Focus Group 2/18/99**

**Pollution**

- Reduce pollution from cars and cigarette smoking.

**Cancer**

- Toxic in neighborhoods (Bayview Hunter's Point).

**Medicare Falls Short**

- Not operated on because they refused the operation.
- Finding dentist that accepts medi-cal for daughter 3yrs.
- How do you access information.

**Immunization**

- Giving shots. Does not know of any denials.
- Had to wait to receive card be able/allowed to get treatment
- How does "Health Children" work?
- What if you do not have a car?
- Took teeth out and was told he would be able to get dentures. Has been denied dentures and ask to pay for dentures.
- Dental service should have more equipment. Sent out to other facilities to get cat-scans.
- Told she was ineligible for six months. Wait six months, was unable to receive services then told she was disqualified because she missed two appointments.
- Received an examination. Shortly after found a cavity that was bothering her before the examination.
- Received a temporary filling, then told she would not be able to be seen for four months.

**STD's**

- Parent intervention, receiving message but not taking it serious.
- Sex education in the school is needed.
- Reduce fear between child and parent. Change image of human body and not be an ugly thing.
- Small group settings for children – networks.

**Plan Parenthood**

- Questions the professionalism
- Given incorrect information

**Manage Care – Emergency Room Treatment**

- Was not satisfied with doctor's treatment. Fever not emergency. "What did I tell you? last visit the doctor call ahead did not have to wait long (1. 5hrs.).

**Young Expecting Mother**

- Wants something of her own
- Saving her money

**Correct Parenting Model**

- How it is to have a baby (fake parenting experience).
- More children activities on an on going bases.
- Mentoring programs – offering multiple mentors.

**Tenderloin Neighborhood Development Corporation**  
**Focus Group 2/18/99**

**Mental Health**

- More “any” information
- Outreach
- More mobile psychiatric person
- Hard to find dual-diagnosis help
- Medication to young children

**Family Counseling**

- Need readily available; where do you go, number to call, person to see.
- Hotlines – where are they? More information
- Hotlines – what do they offer? Called for child abuse the caller got beat up.
- Information – on television, hospitals, onsite family counseling (focus group setup) and one-on-one.

**Mobile Health Van**

- Is anyone eligible for it.
- Action – results
- Booklet to list all the resources
- Change the view of the tenderloin to a family community
- Grandparents- have problems getting help for grandchild because not legal guardian.
- Service providers are short and to the point, do not take the time to explain.
- Sometimes won't service but until the issue is made a problem.
- There is an attitude toward people in the tenderloin.
- Need a referral to get treatment.
- Homelessness – converting broken down buildings
- Make high level official live here than something will be done.
- Task force for all the ills of the community.
- More time to find a place. Six months is not enough time.
- Build housing for families with children and housing for elderly.

**Domestic Violence**

- Where is there counseling?
- Effects child
- Women's group to discuss issues
- Would like to have social service counselors in building.

### *Homeless Prenatal Program Focus Group 2/23/99*

- Told she was not pregnant, but she was pregnant. This happened twice.
- Not enough variety of pamphlets information. – diabetes – lupus
- Some places require a lot of paperwork.
- Some people find the paperwork difficult to complete. The works expect you to know certain information right then.
- Doctor impatient and judgmental.
- Hour wait for five minutes with doctor.
- Prescribe drugs for depress, now having hard time stop using the drug.
- Doctor made her feel belittled. She went for a foot problem and the doctor wanted to keep the visit to only that problem.
- During pregnancy felt and complained of pain on stomach after pregnancy found out she had "neta feitis"
- Women have felt they have ben brushed off. It is a customer service issue. Sometimes they are burned by others but everyone should not have suffered.
- Nurse asks questions, then the doctor comes in asks the very same questions. We feel frustrated.
- Doctor hurt her they became upset because I advised the doctor that it hurt. Challenge is probable because of the insensitivity of a "male" doctor.
- After water broke she advised that she felt like she was about to deliver. She argued with the caretakers to no avail. Shortly after they left the room she delivered by herself.
- Feel the hospital is bias if it is something they support or benefit from like breast feeding by given better treatment i.e. phone call, assistance, showing concern.
- Doctor sensitivity – it is not just a medical issue.
- May benefit by taking someone with you to help listen and cope with the experience.
- Homeless people are judged.
- Emergency room for diabetes. Multiple people questioned her about the problem. (Receptionist, nurse, doctor) not allowed to eat it would affect sugar levels. Person was ruled explaining they are not a restaurant. One hospital cafeteria said they could not feed patients, another did.
- Three times more sensitive. support, follow-up.

## **VI. MAACH Proposed Recommendations**

<u>Youth</u>	Focus Group Recommendations	<u>Page</u>
▪	Teens would like more free health services that do not require the use of insurance claims so that youth have the option of seeking medical care without having to involve parents.	1
▪	Outreach can best be accomplished through the use of flyers and handouts to youth as they walk the streets.	1
▪	Materials should reflect the images and language of the youth culture and clearly indicate who is sponsoring the health service.	1
▪	Extending clinic hours into evening would better accommodate student school and after-school work schedules.	1
▪	Provide more recreational activities and recreational centers for socializing as a deterrent to unhealthy activities.	1
▪	Offer more self-esteem building classes.	1
<u>Emancipated Youth</u>		
▪	A better system of informing youth of their rights and methods of redressing health care complaints.	2
▪	Emancipated youth wanted maintenance of medical coverage after their transition from guardianship.	2
▪	A reduction in the volume of paperwork required to access health care.	2
▪	Co-location of health provider services and eligibility officer.	2
▪	More recreational activities, mentoring programs, life skills training, and self-esteem building classes to help them deal with the stresses in their lives.	2
▪	More extensive advertising of services in school, on billboards and on the radio emphasizing the weight gain aspects of pregnancy as a deterrent to figure conscious teens.	3
▪	Child care classes in school that act as a disincentive to teen parenting by demonstrating the responsibilities associated with child care using infant simulations or "fake babies".	3
▪	Discussion sessions led by teen parents explaining the life changes that they encountered as a result of teen pregnancy and parenting.	3
▪	When hotlines/ help-lines are used the person answering the line should listen and not ask questions.	3

### Focus Group Recommendations

<u>Homeless Pregnant Women</u>	<u>Page</u>
<ul style="list-style-type: none"> <li>Women wanted doctors to understand that prescribing counseling may be just as important as prescribing medication to address their depression.</li> <li>They would like health care staff to consider all of the concerns of the patient and to write patient comments into their medical records.</li> <li>Doctors should develop a greater sensitivity to the needs of patients and begin to embrace a team effort approach toward health care that includes the patient as part of the team.</li> <li>Assigning advocates to make certain women's needs are being met during the examination process would be helpful.</li> <li>Greater postnatal care for infants and mothers whether or not the mother has committed to breastfeeding.</li> <li>An information hotline for young mothers or new mothers.</li> </ul>	<p>7</p> <p>7</p> <p>7</p> <p>7</p> <p>8</p> <p>8</p>

#### Homeless Families

<ul style="list-style-type: none"> <li>Families wanted public agencies to make taxi vouchers more available so they had greater ease and less expense accessing health care facilities, especially at night.</li> <li>Dental coverage should be expanded to include replacement of extracted teeth.</li> <li>Homeless facilities should offer some dietary accommodations for individuals with restrictive diets such as diabetics.</li> <li>Families indicated a need for more recreational activities for the children in homeless centers as a way to occupy them while adults worked through the problems associated with this situation.</li> </ul>	<p>6</p> <p>6</p> <p>6</p> <p>6</p>
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#### Paroled Men in Recovery

<ul style="list-style-type: none"> <li>Men felt that they could not adequately address their health needs given the limited \$200 stipend paid to them upon release from prison and therefore wanted expanded subsidized health care that included vision, dental, and treatment for Hepatitis.</li> <li>More accurate descriptions of available free health care resources and the facilities providing services was needed as parole officers provided conflicting information to parolees.</li> </ul>	<p>4</p>
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### Focus Group Recommendations

<u>Paroled Men in Recovery</u>	<u>Page</u>
<ul style="list-style-type: none"> <li>▪ Transportation vouchers to health care facilities was an improvement men wanted. 4</li> <li>▪ A scheduled transport should be maintained between homeless shelters and county hospital facilities. 5</li> <li>▪ Many of these men were sometimes residents of homeless shelters and felt that procedures for the sanitary operation of homeless shelters should be established including mandatory de-liceing, organizing residents into work crews to maintain port-a-potties and laundering residents' clothes. 5</li> <li>▪ Women residents should be given birth control pills 5</li> <li>▪ There should be on-site medical care.</li> <li>▪ Health care workers should take the opportunity to educate their audience by offering workshops such as accessing the temporary job market and by offering incentives for participation. 5</li> <li>▪ Schools should do more to help youth by providing life skills training in the area of parenting classes, marriage/relationship counseling, and anger management classes. 5</li> </ul>	

### Immigrants

- This community wanted the public health department to train community people to do outreach on health issues. 9
- Identify "model" social service staff and use them to train other staff in serving and relating to the immigrant population 9
- Providing for sliding scale fees that do not require governmental paperwork was recommended instead of government subsidized insurance that is a deterrent to many immigrants who require low cost health care but fear that accepting free services may label them a burden, thereby hindering their ability to attain citizenship. 10
- The group felt there is a need for affordable health care for the working poor. 10
- They wanted information on the health care rights of illegal aliens. 10

<b>Focus Group Recommendations</b>	
<u>Parents of Children with Special Needs</u>	<u>Page</u>
<ul style="list-style-type: none"> <li>▪ Reducing waiting room time for special needs children by calling them first.</li> <li>▪ Funding a parent- developed resource guide that allows families to pool their knowledge of available resources.</li> <li>▪ Better training of medical staff to eliminate prejudices and promote better understanding and care of special needs children.</li> <li>▪ Parents requested the funding of advocacy agencies to assist them in maneuvering system barriers to adequate health care such as the tendency to limit diagnosis in order to limit the resources that will have to be expended for treatment; slow recognition by educational institutions of developmental or learning disabilities in children, allowing them to suffer long periods of poor performance before taking corrective measures; and doctors or specialists who discount parents' knowledge of their children when rendering medical diagnosis or treatment.</li> <li>▪ They called for more advisory board appointments believing that overall relationships would improve when parents of children with disabilities and appropriately aged youth with special needs, begin to sit on more advisory or community boards.</li> <li>▪ Parents wanted the county's public health agency to begin collecting and reporting statistics on special needs children, especially adolescents who are at risk for negative behaviors such as substance abuse, teen pregnancy, and suicide.</li> </ul>	<p>11</p> <p>11</p> <p>11</p> <p>11</p> <p>12</p> <p>12</p>

**Focus Group Recommendations**

<u>Bayview/Hunter's Point Community</u>	<b>Page</b>
▪ Residents wanted a major health care facility built in the district.	13
▪ They wanted the environmental causes of asthma clusters in the area Identified and instruction in asthma management provided to residents.	13
▪ It was suggested that there be increased nutritional education for youth. children.	13
▪ Sex education classes offered in school should emphasize the consequences of certain behaviors such as using pictures to depict what sexually transmitted disease looks like on the human body.	13
▪ Help-lines staffed by respected community members are preferable.	14
▪ More recreational activities are needed for youth, especially girls.	14
▪ Self-esteem classes for teens were requested.	14
▪ Pregnant teens wanted co-location of prenatal and delivery services.	14
▪ Lack of affordable, safe housing was a concern of pregnant teens Who did not plan on residing with their parents.	14
<u>Tenderloin Community</u>	
▪ Residents wanted the community to be considered a family community in the hopes that it would then be provided with the basic needs like recreational facilities for youth; health care facilities for the general public; and appropriate policing that allows people to safely walk in the neighborhood with their children	15
▪ A task force should be assembled to discuss problems in the Tenderloin.	15
▪ There should be greater outreach to mentally disturbed through use of mobile units of psychiatric and counseling professionals who could administer to the needs of people on the street.	15
▪ Residents wanted a health care resources directory.	15
▪ Families felt that on-site family counseling services located inside residential apartment buildings was desirable.	15
▪ More home visits by public health nurses was requested.	16
▪ It was felt that abandoned buildings should be opened for use by the homeless.	16

<b>Focus Group Recommendations</b>	
<u>Inner Mission Community</u>	<u>Page</u>
▪ Residents called for increased recreational activities for youth as well as mentoring and career guidance programs.	17
▪ Parents wanted an explanation of why Tylenol is frequently prescribed as the appropriate medication.	17
▪ Residents wanted neighbor-hood individuals to be trained to provide first aid consultations in the community.	18
▪ They wanted to be informed of the legal ramification of providing first aid care to non-family member.	18







### **III. LOCAL PLAN**

The foundation for the 5-year plan was the quantitative data in the Child Health Report and the qualitative data was derived through community focus groups.

The San Francisco MCAH Program has been tracking specific indicators and developing data reports regarding the health and well being of childbearing women, children and adolescents for the past 10 years. These indicators were the basis for the community needs assessment. The Program will continue to develop data reports and modify objectives based on current needs.

Recipients of services, the MCAH Advisory Board, and MCAH staff provided qualitative information, which was used to develop the 5-year plan. The plan will address the need for improved health services, more services for adolescents, and more dental services.



## MCAH PLAN AND OBJECTIVES

Objective 1 Increase to 90% the percentage of all pregnant women who receive early prenatal care (first trimester).		
Activity	Outcome	Timeline
<p>1.1 Work with community leaders/organizations and church groups who will assist in conveying the message of the importance of early prenatal care.</p> <p>1.2 Share resource information regarding available prenatal care, community forums, health fairs, referral and information sites.</p> <p>1.3 Continue incentive program supporting early prenatal care, especially targeting African American and Hispanic women.</p> <p>1.4 Coordinate with family planning and pregnancy testing sites to refer women for early prenatal care.</p>	<p>Ten groups will be contacted per year</p> <p>Staff will participate in two community fairs/forums per year</p> <p>African American and Hispanic women will improve rate of entry into prenatal care by 2% per year.</p>	2000-2005
Objective 2 Reduce low birth weight of African Americans to no more than 8 percent of live births.		
Activity	Outcome	Timeline
<p>2.1 Continue outreach program targeting African American pregnant women (BIH and Sistah, Sistah Program).</p> <p>2.2 Participate in Health Fairs that target African Americans to inform them about the importance of good nutrition and the WIC Program benefits as well as provide on-site enrollment.</p> <p>2.3 Review and report on African American infant birth and other related statistics.</p> <p>2.4 Identify families at-risk and provide educational and social support services (BIH Project and others).</p> <p>2.5 Continue coordination of social work, health care, substance abuse treatment, education, etc. services that assist high-risk families.</p> <p>2.6 Review and report on infant mortality cases in San Francisco through FIMR. Prepare annual report of findings.</p> <p>2.7 Advocate for and facilitate programs, which reduce tobacco use among pregnant women.</p> <p>2.8 Continue the CPSP/WIC collaboration project re shared protocols, standards, etc.</p>	<p>200 pregnant African American women will be followed-up each year.</p> <p>Low birth rate will decrease 2% per year.</p> <p>A FIMR report will be developed each year.</p>	<p>2000-2005</p> <p>2000-2003</p> <p>2000-2005</p>

Objective 3 Reduce infant mortality rate for African Americans to no more than 7 per 1000 live births.		
Activity	Outcome	Timeline
3.1 Develop an outreach program targeting African American pregnant women in collaboration with community.	Staff will participate in 2 Health Fairs a year.	2000-2005
3.2 Participate in Health Fairs that target African Americans to inform them about the importance of prenatal care.		
3.3 Review and report on African American infant birth and other related statistics. Distribute information to the community, providers and advocates.	Child Health Report	2001 and ongoing
3.4 Identify families at risk and provide educational and social support services (BIH Project and Sistah, Sistah Program).	Bimonthly Perinatal Substance Abuse Committee.	2000-2005
3.5 Advocate for and continue to facilitate coordination of social work, health care, substance abuse treatment, and education services that assist high-risk families.		
3.6 Review and report on infant mortality cases in San Francisco through FIMR.	Reduce by 25% substance abusing pregnant women.	2000-2005
3.7 Continue to advocate for culturally sensitive services, particularly for African Americans, Latinos, Asians and Filipinos.		
3.8 Reduce or mitigate substance abuse, domestic violence & other stressors among families through ongoing advocacy, coordination and referral for treatment.	Breastfeeding rates will increase 5% per year.	2000-2005
3.9 Advocate for and facilitate programs, which reduce tobacco use among pregnant women.		
3.10 Increase rate of breastfeeding among low-income women through provider training and awareness and implementation of MCAH breastfeeding plan.		

Objective 4 Reduce teen pregnancies to 5 percent or less of total births.			
Activity		Outcome	Timeline
4.1 Make information on family planning resources in San Francisco available to all WIC participants and adolescent providers.		Work with five ethnic programs offering family planning services.  Bimonthly Pregnancy Prevention Committee meetings. Five programs for males will be developed.	2000-2005
4.2 Provide culturally appropriate staff training on the importance of family planning and current family planning methods.			2000-2001
4.3 Continue coordination efforts among teen pregnancy providers.			2000-2005
4.4 Encourage and assist in the implementation of teen pregnancy prevention programs.			2000-2005
4.5 Establish male involvement programs with community partners and other concerned providers.			
Objective 5 Increase by 10 percent the number of children enrolled in Healthy Families Program.			
Activity		Outcome	Timeline
5.1 Continue participation in county planning effort for enrollment of families in Healthy Families.		Minutes of monthly meeting.	2000-2001
5.2 Conduct training for providers and community organizations that serve women and children regarding Healthy Families Program.		Three trainings will be presented.	2000-2001
5.3 Make space available for enrollees at all WIC sites.		Minutes from meetings	2000-2005
5.4 Continue staff participation in Department work group on Healthy Families Program.			
Objective 6 To create a more friendly health environment for women, children and adolescents			
Activity		Outcome	Timeline
6.1 Coordinate work group with primary care sites to develop proposal for making relevant DPH sites more child and women friendly.		Three sites will participate per year.	2000-2003
6.2 Develop "boiler plate" proposal for DPH service sites to improve service environment for women and children.			
6.3 Create evaluation tools to assess staff interaction between each other and recipients of service i.e. Mystery Shopping, Client and Staff Surveys.		Annual staff and client survey. Training schedule.	2000-2005 2000
6.4 Identify training needs for staff			

Objective 7 To improve adolescent health and assure accessible, high quality, culturally competent, and coordinated adolescent health services.		
Activity	Outcome	Timeline
7.1 Coordinate planning for adolescent health services in San Francisco. Collaborate with School District, adolescent service Providers and advocacy groups.	Minutes of meetings.	2000-2005
7.2 Encourage youth involvement in all youth planning activities.	Youth participation on committee.	2000-2005
7.3 Participate in statewide planning for adolescent services. Ensure that documents developed are disseminated in San Francisco.		
7.4 Collaborate with DHS when transitioning adolescents from Foster Care to ensure the youth can access appropriate health care.	Documentation of services.	
Objective 8 To assure that women, children and youth have access to appropriate oral health and dental prevention and treatment services and education.		
Activity	Outcome	Timeline
8.1 Provide screening for preschool children.		
8.2 Develop Sealant Program for children prior to third grade.	Schedule of screening dates.	2000-2001
8.3 Ensure that information of services is available at WIC sites, childcare sites, and outreach programs.		
8.4 Continue to coordinate citywide dental task force working on issues of dental capacity.	Report of recommendations.	2000-2001
8.5 Coordinate with prenatal providers and outreach programs to ensure that pregnant women have access to dental care.	Documentation of contacts.	2000-2005





## **IV. APPENDIX**

- **The Health and Well-Being of  
Children and Youth in San  
Francisco**



# The Health and Well-Being of Children and Youth in San Francisco



*San Francisco Department of Public Health  
Coordinating Council for Children, Youth, and Families*

*November 1998*

## Coordinating Council for Children, Youth, and Families

The Coordinating Council for Children, Youth, and Families of the San Francisco Department of Public Health is an agency-wide forum comprised of representatives of the Department's child and youth serving programs established to provide strong leadership for policy development, priority-setting, and planning to assure the best possible health and well-being of San Francisco's children, youth, and their families.

Co-Chairs of the Council are:

- Mildred Crear, Director, Children, Youth, and Families Section, Population Health and Prevention Division
- Janet Murphy, Primary Care Administrator, Community Health Network

Members of the Council as of Summer 1998 include:

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**THE HEALTH AND WELL-BEING OF  
CHILDREN AND YOUTH IN SAN FRANCISCO**

**San Francisco Department of Public Health  
Coordinating Council for Children, Youth, and Families  
November 1998**



## ACKNOWLEDGMENTS

This report was developed under the auspices of the Coordinating Council for Children, Youth, and Families of the San Francisco Department of Public Health (SFPDH). Co-Chairs of the Council are Mildred Crear, Director of the Children, Youth, and Families Section within the Population Health and Prevention Division and Janet Murphy, Primary Care Administrator within the Community Health Network. Significant staff support for the report was provided by the Department's Office of Policy and Planning. The Coordinating Council is a Department-wide body, advocating on behalf of children, youth, and their families, and coordinating policies and programs within the Department pertaining to children and youth.

The Child and Youth Health Report Committee under the Coordinating Council for Children, Youth, and Families guided the overall planning and development of the report, provided data, and wrote the report. Members of the Committee included staff from the Department as well as representatives from the Starting Points Initiative within the Mayor's Office of Children, Youth, and Their Families (MOCYF) and staff from the San Francisco Injury Center who provided significant assistance for the project. Members of the Committee included:

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Members from the Department's Coordinating Council for Children, Youth, and Families led the development of the "Summary" of the report. The Council will oversee the dissemination of the report, and will facilitate discussions within the Department and in the community to address the findings of the report.

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## EXECUTIVE SUMMARY

The Health and Well-Being of Children and Youth in San Francisco, 1998 provides an overview of the children and youth population in San Francisco by presenting a variety of health status indicators. Not all indicators are strictly health or medically related, but include socio-economic measures that traditionally have been seen as influencing health outcomes and the health status of individuals and populations. The report provides Healthy People 2000 objectives, when applicable, as a standard by which San Francisco can be compared to the nation as a whole. Key findings of the report are:

- *Demographics; Socio-Economic Status:* San Francisco has a smaller proportion of children and youth within the general population. Like the City's overall population, San Francisco's child and youth population is more racially/ethnically diverse population than the child and youth population in the rest of the State. The City's children and youth tend to be concentrated in certain areas of the City (about half reside within six zip codes). An estimated 22% of San Francisco's children and youth under age 18 were in poverty in 1993, slightly lower than the statewide and national rate. In both San Francisco and nationwide, the poverty rate among children is much higher than the poverty rate among non-elderly and elderly adults. In 1996/97, nearly one-third of students enrolled in the San Francisco Unified School District spoke limited English or were non-English speaking.
- *Perinatal Health:* San Francisco has a lower birth rate than the statewide average. In 1996, two-thirds of all births in San Francisco were to women of racial/ethnic minorities. In the same year, 86% of San Francisco women giving birth received early prenatal care, close to the Healthy People 2000 objective of 90%. However, entry into prenatal care was much lower (76%) among African American and Latina women. Latinas and African Americans have 77% of all births to adolescents.
- *Deaths:* From 1990 to 1995, half of the deaths among San Francisco children and youth from birth to age 24 were in the 15 to 24 age group, and 35% were among infants less than age 1. Homicide was the leading cause of deaths, with most homicide deaths occurring among youth ages 15 to 24. Black children and youth of all age groups had many deaths relative to their share of the population, and the discrepancy was greatest among Black youth ages 15 to 24.
- *Injuries:* From 1986 to 1995, the three leading causes (mechanisms) of injury deaths among San Francisco children and youth ages 0 to 18 were firearms (28% of all injury deaths), motor vehicle traffic (26%), and suffocation (11%). Over half (55%) of injury deaths were unintentional. In 1995, the three leading causes of injury hospitalizations were falls (25% of injury hospitalizations), motor vehicle traffic/non-traffic (16%), and poisoning (14%).
- *Childhood Lead Poisoning:* From 1991 to 1996, 8.4% of San Francisco children with blood lead level screening had initial blood levels that were elevated (greater than or equal to 10 ug/dL). Less than 4% of children had blood lead levels which required case management services (greater than or equal to 15 ug/dL), and this percentage has been dropping (2.0% in 1996) which is similar to national trends. The most common environmental sources of lead for San Francisco children with elevated blood lead levels were lead-based paint, lead-contaminated soil, and lead dust.

- Immunization and Communicable Diseases:* San Francisco two-year olds had a 65% completion rate for immunizations in 1996, compared to a statewide rate of 57% and the Healthy People 2000 goal of 90%. From 1990 to 1997, San Francisco achieved the Healthy People 2000 goal to completely eliminate diphtheria and tetanus among children and youth ages 25 and younger, but did not completely eliminate measles and rubella. From 1990 to 1996, new reported cases of active tuberculosis among children and youth ages 0 to 18 represented 4% of all cases in the City. However, the rates among both children and adults are decreasing, similar to state and national trends. Nearly all (92%) new TB cases among children and youth were in non-White racial/ethnic groups.
- Sexually Transmitted Diseases; HIV/AIDS; Sexual Behavior:* From 1992 to 1996, both chlamydia and gonorrhea rates declined substantially among San Franciscans youth ages 15 to 19 and in San Franciscans of all age groups. However, youth ages 15 to 19 continue to have the highest rates of both chlamydia and gonorrhea in the City, compared to all other age groups. Fifteen percent of San Francisco men who have sex with men (non-injection drug users) who are age 29 and under are estimated to be infected with HIV. Less than 1% (0.06%) of San Francisco infants and children age 13 or younger are estimated to be infected with HIV. Twelve percent of all AIDS cases in the City are among children and youth and young adults up to age 29 which is less than the U.S. average (19%). These cases disproportionately occur among men who have sex with men ages 25 to 29, two-thirds of these are Whites. Similar to the City as a whole, the number of AIDS cases in the 0 to 29 age group is declining. In 1997, 14% of San Francisco public middle school students and almost 30% of high school students reported that they engaged in sexual intercourse at least once in their lifetime.
- Mental Health:* From 1990 to 1995, suicide was the second leading cause of death for San Francisco youth ages 15 to 24. Nationally, suicide is the third leading cause of death for this age group. One quarter (24%) of San Francisco middle school students and 20% of San Francisco high school students said that they had seriously considered suicide.
- Oral Health:* San Francisco is the only 100% flouridated city and county in the State, achieving the Healthy People 2000 objective for flouridation. However, 66% of public elementary school children in San Francisco had dental caries ("cavities") including about half that were untreated, compared to the Healthy People 2000 goal that less than 35% of children ages 6 to 8 have one or more caries.
- Child Abuse and Neglect:* In 1996, there were over 3,000 San Francisco children and youth ages 0 to 17 in foster care, the highest rate per capita in the State and over twice the statewide rate. The number of San Francisco children and youth in foster care increased dramatically between 1991 and 1993, but remained relatively stable from 1993 to 1996. African Americans represent 72% of San Francisco children and youth in foster care.
- Homelessness:* In 1996/97, the Connecting Point Housing Crisis Hotline received calls seeking assistance from 902 families with over 1,500 children of which half were age 5 or younger). Over a two-year period from 1995 to 1997, over 676 families were housed in and subsequently exited from one of the City's four largest family shelters. The three most common causes of

homelessness as identified by the families were being evicted from their homes, substance abuse, and dangerous living environments.

- *Crime:* In 1996, juveniles up to age 17 represented 8% of all arrests in the City. The number of juvenile arrests declined by 26% from 1987 to 1996. The number of juvenile arrests for homicide has declined substantially by 1996 (8 arrests) from its peak in 1993 (34 arrests). Juvenile crime in San Francisco is concentrated in a few areas of the City.
- *Alcohol, Drugs, and Tobacco Use:* Over half of both middle and high school students in San Francisco public schools reported that they had tried alcohol at least once in their lifetime. Reported use of drugs (such as marijuana; inhalants; cocaine) among these students rose from 1992 to 1997. From 1994 to 1996, the number of children and youth under age 25 killed in alcohol-involved collisions declined significantly. San Francisco has achieved the Healthy People 2000 objective of reducing deaths caused by alcohol-related motor vehicle crashes among youth ages 15 to 24. In 1997, 13% of San Francisco public middle school students and 19% of high school students reported that they had smoked cigarettes at least once in the previous month. In 1997, over one-third of public middle school students and over one-half of public high school students in San Francisco reported that they had tried smoking at least once in their lifetime. Thirteen percent of middle and 19% of high school students reported that they had smoked in the past month.
- *Access To Health Care Services:* In 1996 and 1997, children and youth ages 0 to 17 comprised about 10% of the population without health insurance in San Francisco. The percentage of children who are uninsured is lower in the San Francisco Bay Area than in other regions of the state. Latino children in California are much more likely to be without health insurance compared to children in other race/ethnic groups. In 1995, most uninsured children in California lived in families with at least one working parent, and children who are low-income are more likely to be uninsured. In 1997, about 29% of San Francisco's residents under age 21 received Medi-Cal, although there were wide variations across neighborhoods. Sixty one percent of the Bayview Hunters Point population under age 21 received Medi-Cal, followed by South of Market at 48%.

A number of major themes were identified based on the broad range of information presented in the report. These themes include:

- The link between poverty and poor health (poverty was usually inferred based on residence of the individual or on program eligibility rules);
- The occurrence of health conditions are commonly associated with specific age groups;
- The impact on health status of social and economic factors such as environmental pollutants, violence, substance use, and lack of access to health care services;
- The consistent disparity in the health and well-being of African American children and youth compared to children and youth of all other race/ethnicities;
- The incidence of violence in the lives of children and youth in the City as reflected in rates of suicide, homicide, injury risk behaviors, and child abuse and neglect;
- The relationship between environments which encourage risky health behaviors and negative health outcomes; and
- The many limitations of existing health status data and the need to more systematically track the progress of health conditions in children and youth.

## INTRODUCTION

### Purpose

The purpose of The Health and Well-Being of Children and Youth In San Francisco, 1998 report is to assess the health of the child and youth population in San Francisco by identifying key indicators of health status for children and youth. The report was developed through a process of collecting, validating, and presenting current health data. The report is meant to:

- Provide basic information for planning by the San Francisco Department of Public Health and the community;
- Serve as a general reference document on the health and well-being of children and youth;
- Serve as an educational tool for local individuals, organizations, and communities;
- Serve as a tool for monitoring and evaluating the health status of children and youth in San Francisco; and
- Provide information to assist in advocating on behalf of the needs and concerns of children and youth.

The report is intended for a wide audience including staff from San Francisco Department of Public Health and from other City agencies; community leaders, including policy makers, professionals and laypeople; parents; advocates in the public and private sectors; and anyone who has an interest in the health and well-being of children and youth.

### Background

The Health and Well-Being of Children and Youth in San Francisco, 1998 is the fourth edition of a report originally published in 1990 as part of the project, "Health of the Uninsured and Underinsured: Developing a System to Monitor Trends." The 1990 report was a collaboration between the University of California at San Francisco and the San Francisco Department of Public Health funded by the W.K. Kellogg Foundation. Subsequent to the 1990 report, the San Francisco Department of Public Health updated the report in 1992 and 1994.

In 1994, the San Francisco Department of Public Health's Child Health Initiative for Immigrant and Refugee Newcomers (CHIRN) Project issued Newcomer Children in San Francisco - Their Health and Well-Being, as a companion to The Health and Well-Being of Children and Youth in San Francisco (1994). The CHIRN report was developed in response to a concern that the problems and needs of the newcomer children and youth population were not being addressed. The report included quantitative and qualitative information on health indicators, some which overlapped with The Health and Well-Being of Children and Youth in San Francisco. At this time, the CHIRN report may provide readers with historical information, but the current Health and Well-Being report is more instructive for planning purposes.

### Development of This Report

This report was developed under the auspices of the San Francisco Department of Public Health's Coordinating Council for Children, Youth, and Families. A Child and Youth Health Report Committee under the Coordinating Council, comprised of representatives from the San Francisco Department of Public Health (SFDPH), the Starting Points Initiative within the Mayor's Office of Children, Youth, and Their Families (MOCYF), and the San Francisco Injury Center, developed the

report. The Committee provided ongoing oversight of and direction to the report, and was responsible for identifying and gathering data and information from a variety of health, social service, juvenile justice, mental health, education, and other agencies.

The Department's Coordinating Council for Children, Youth, and Families provided leadership and guidance in developing the "Summary" section of the report. The Coordinating Council will also take the lead in disseminating the report and its findings, and in encouraging ongoing use of the report for planning and monitoring of children and youth health services, both internally within the Department and externally within the San Francisco community.

### **Indicator Selection**

In developing the report, the Child and Youth Health Report Committee reaffirmed both the approach to and content of the report based on several underlying principles. These principles have been used in developing previous editions of this report, and are as follows:

- Encompass a Broad View of "Health": Monitoring the health and well-being of children and youth requires examination of a broad range of information reflecting the overall status of this population. This should encompass indicators of social, economic, and educational status as well as traditional medical indicators.
- Utilize Population-Based Data and Program-Specific Utilization Data: Where possible, the report will be based on data covering the whole population of San Francisco children and youth. When direct population-based information is not available, the report incorporates data on utilization of services to get an indirect view of the health status of children and youth and the adequacy of health services for at least the individuals in the population covered by these programs.
- Focus on Most Vulnerable Subgroups: In addition to monitoring the citywide health status of children and youth in San Francisco, a priority for this report is to focus on the health and social conditions of those groups most vulnerable to poor health by virtue of poverty and/or a lack of health insurance.
- Utilize the Most Readily Available and Reliable Data: In order to identify trends in health status, the report, whenever possible, uses data sources which are readily accessible, reliable, and generally available on an annual or periodic basis. As a result, the report does not include some desired indicators. In other cases, the report may include indirect measures (such as program utilization data) for health status information that is readily available.

The Committee utilized a set of criteria to determine which data indicators to include in the report. These criteria were also used in developing previous versions of the report. The criteria were:

- Severity - how badly the problem impairs health.
- Extent - how many children and youth are affected by the problem including the number of children and youth impaired, at risk, and/or indirectly affected.
- Trends - the anticipated future if no action is taken, whether the problem is getting better or worse, and whether the problem is being addressed.
- Community Concern - the community's awareness of and concern for the problem, and its willingness to support an effort to ameliorate the problem.
- Equity - how much the problem reflects unequal access to care due to financial, geographic, and attitudinal barriers; how preventable the problem may be.
- Costs - how much the problem "costs" the system and the population.

## **Overview of Report Contents**

This report is organized into chapters representing different groups of related indicators. Each chapter contains recent data by appropriate descriptors such as gender, age and race/ethnicity groups, and geographic markers (usually zip code). Whenever possible, the report presents data on trends over time, although the availability of historical data varies widely for each health indicator. In addition, the report compares San Francisco to national Healthy People 2000 objectives whenever possible. The appendix provides detailed data and other information for reference.

## METHODOLOGICAL ISSUES

In the process of preparing this report, a number of methodological issues related to the limitations of the data emerged. Many of these issues were identified in the previous editions of the report and continue to be relevant.

### Population Data

As the 1990's progress, population estimates based on the most recent decennial Census (1990) have become increasingly unreliable. Various agencies and programs tracking health data use a variety of sources to calculate population levels. This report reflects these different methods and sources of population data available including:

- The 1990 U.S. Census conducted by the U.S. Bureau of the Census;
- Population estimates developed by the California Department of Finance (DOF), Demographic Research Unit, for each year since 1990. DOF population figures are required to be used by state agencies.
- Estimates developed by CACI Marketing Systems, in the Sourcebook of Zip Code Demographics, 11th Edition (1997) for the 1996 San Francisco population by zip code. In The Health and Well-Being of Children and Youth In San Francisco, we use CACI's data after adjusting to the DOF county totals.

Throughout the report, we have noted the source for population data used as the denominator to calculate rates for the data being presented. Until another census is conducted in the Year 2000, the advisory group overseeing future reports must continue to recognize the limitations of estimated population data.

### Race/Ethnicity

The diversity of the San Francisco population makes it especially important to have updated race/ethnicity information for the population. However, accurate, updated racial/ethnic population data are not readily available, and many programs still rely on the 1990 Census for racial/ethnic population data. Projections may be of limited usefulness in assessing the needs for population-specific services and may not accurately reflect the current situation.

In addition, data sources do not all utilize the same categories, definitions, and methods of collecting information on racial/ethnic populations. For some databases, the provider or other worker determines the race/ethnicity of the client; for other databases, including the U.S. Census, the person is asked to self-identify. Asian ethnicities of widely differing cultures and histories are often combined in databases, and Asians as a whole are often lumped together with "Others," who in turn are often combined with "Unknown." Persons of mixed racial background, and other smaller groups are coded differently in different databases. Persons of mixed race/ethnicity are sometimes coded as "Other," and in other cases are coded as the race/ethnicity the person most strongly identifies with. As a result of these incongruities, substantial underreporting of certain ethnicities occurs in some databases. In short, differences in methods of data collection and categorization by different agencies and programs may make aggregations of and comparisons between them problematic. As a rule, this report uses the terminology for racial/ethnic categories used by the data sources. California DOF population estimates

use these race/ethnicity categories: White, Hispanic, Black, Asian/Pacific Islanders, and American Indian.

Birth certificates identify the race/ethnicity of mother and father but not the race/ethnicity of the infant. Infant race/ethnicity is usually reported by the race/ethnicity of the mother. Death certificates identify the person's race/ethnicity by asking a relative or friend or by the funeral director's observation.

### **Age**

Age criteria differs across health and human services programs serving children and youth contributed data for this report. For example, most San Francisco Department of Public Health child- and youth-serving programs report on children and youth up to 18 or 19 years of age. However, reporting of AIDS surveillance data designates youth in the age groups of 13 to 19 and 20 to 24. The criminal justice system designates age 18 as the transition from youth to adulthood. The National Center for Health Statistics age categories covering children and youth are <1, 1 to 4, 5 to 14, and 15 to 24. These age groups are also used by many California Department of Health Services programs.

These differences complicate the comparison of rates across programs because the denominators may differ. Whenever possible, this report uses the following age groups: ages 0 to <1, 1 to 4, 5 to 9, 10 to 14, 15 to 17, 18 to 19, and 20 to 24.

### **Geographic Data**

In this report, neighborhoods are usually defined by zip code areas, an easily accessible identifier of location. These zip code areas may not reflect neighborhoods as they are defined elsewhere, and may result in combining or splitting social, economic and cultural groups. The changing definition and composition of neighborhoods and the lack of historical tracking by zip code make trend analysis by geographic area difficult. While using census tract data allows for comparing areas by rate per population as measured by the U.S. Census, data by census tract is not collected by the majority of health-related data sources.

### **Calculations of Incidence and Prevalence Rates**

It is standard public health practice to look at incidence (number of new cases) and prevalence (number of total cases) of a disease or condition in relation to a designated population over a given time period (rates) rather than the raw number of cases in order to gauge the relative impact of conditions on the population. This allows more meaningful comparisons with data from other counties and states on different populations.

However, the most accurate population counts for any year subsequent to the decennial Census, are only considered estimates, and are not usually available by gender, age, race/ethnicity, and other breakdowns. In addition, population data at the neighborhood level (e.g., by zip code) is even more difficult to obtain. In general, census data does not reflect the more recent and rapid population changes that occur in locales such as San Francisco.

### **Service Units**

This report presents utilization data as it is maintained by the data source. In some cases, utilization is measured by the quantity of services provided (number of visits or assessments, for example). Other programs measure utilization by calculating unduplicated number of clients served. Because different

service providers define utilization differently, aggregating across programs to evaluate services to a specific population may not yield a consistent or accurate picture of what services were accessed and by whom. The reader is advised when reviewing utilization data to note what units are being reported and for what sector of the population.

### **Citations and References**

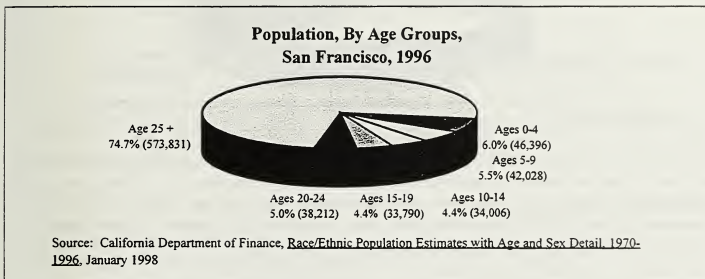
This report required aggregation of data from numerous sources including agencies and programs which generate and maintain raw data, data reports, program descriptions, and other reports. We include in this report, through citations in footnotes, specific source information so that interested readers can access the information on their own. In many cases, health data, mainly data collected and maintained by public agencies, has become easily available through the Internet – a significant change since the previous report.

## DEMOGRAPHICS

### Population

San Francisco has a distinct demographic profile including a smaller proportion of children and youth within the total population and a more racially/ethnically diverse population than the rest of the state. San Francisco's total population (all age groups) rose from 723,900 in 1990 to 768,263 in 1996, a 6.2% increase.<sup>1</sup>

**By Age.** In 1996, an estimated 194,432 children and youth ages 0 to 24 resided in San Francisco, comprising 25.5% of the City's population. This represents only a 1.1% increase of individuals in this age group compared to 1990 (192,358). From 1990 and 1996, there was a large decrease in the number

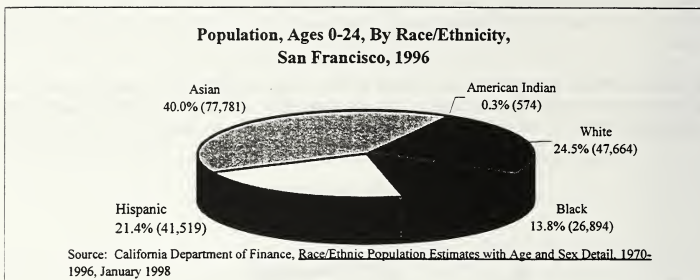


of young adults ages 15 to 24 in the City, which was more than counterbalanced by large increases in pre-schoolers (ages 0 to 4), young children (ages 5 to 14), and adults (ages 25 to 64). The number of elderly in the population has remained almost exactly the same over the six-year period. (Refer to the Appendix for detailed data.)

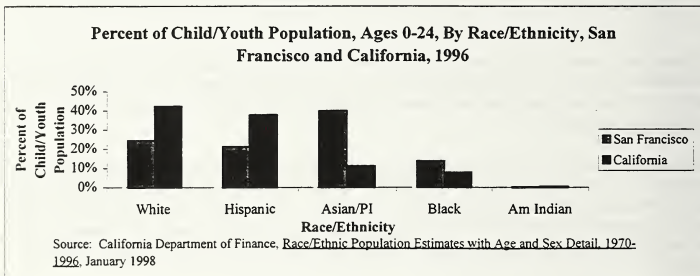
Compared to the state as a whole, San Francisco has a smaller proportion of children and youth in the population. In 1996, children and youth ages 0 to 19 represented 30.5% of the state's population, but only 15.9% of San Francisco's population. In the same year, youth ages 20 to 24 represented 6.5% of the state's population compared to 5.0% of San Francisco's population. Conversely, a larger part of San Francisco's population was comprised of adults ages 25 and over (74.7%), compared to the state (63.0%).

<sup>1</sup> California Department of Finance, Race/Ethnic Population Estimates with Age and Sex Detail, 1970-1996, January 1998. Racial/ethnic categories are those designated by the data source.

By Race/Ethnicity. In 1996, Asians were the largest racial/ethnic group among the San Francisco child and youth population ages 0 to 24, representing 40.0% of the under age 25 population. Whites were the second largest group (24.5%), followed by Hispanics (21.4%), Blacks (13.8%), and American Indians (0.3%).



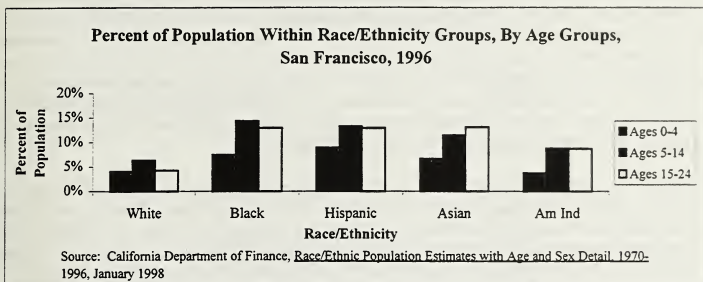
San Francisco's child and youth population is racially/ethnically more diverse compared to the child and youth population statewide. Non-White racial/ethnic groups comprise 75.5% of San Francisco's children and youth population compared to 57.6% statewide. San Francisco has a much larger percentage of Asian/Pacific Islanders and Black children and youth compared to the state while the



state has a higher percentage of Hispanic children and youth. American Indian children and youth comprise less than 1% of the child and youth population in both the City and the state. (Refer to the Appendix for detailed data.)

In general, non-White racial/ethnic groups in San Francisco tend to be relatively younger populations compared to the White population. For example, in 1996, close to one-third of the City's Hispanic (35.2%), Black (34.9%), and Asian/Pacific Islander (31.3%) populations were children and youth ages 0

to 24 compared to only 14.8% of the City's White population. Children and youth ages 0 to 24 represented 21.3% of the American Indian population in San Francisco. Conversely, a larger



proportion of the City's White population (85.2%) was comprised of adults ages 25 and older, compared to the Asian (68.7%), Black (65.1%), Hispanic (64.8%), and American Indian (78.6%) populations. (Refer to the Appendix for detailed data.)

**By Zip Code.** San Francisco is comprised of a diverse set of neighborhoods with residents that differ by age, ethnicity, income, health status, and other characteristics. Examining population characteristics at the zip code level can be a useful way to identify specific needs and to target resources most appropriately. However, population estimates more recent than the 1990 Census at zip code or neighborhood level are not widely available. CACI Marketing Systems provides is one of the available sources for zip code level population estimates.

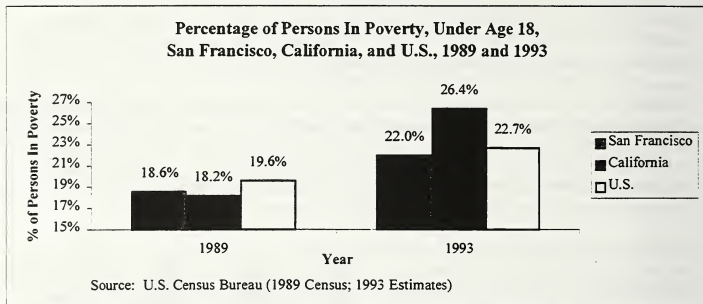
According to this source, all except one of San Francisco's 26 residential zip codes (or zip code clusters) have a population of children and youth ages 0 to 17 of at least 1,500. Almost one-quarter (25%) of the City's children and youth ages 0 to 17 reside in two zip code areas, 94110 (Inner Mission/Bernal Heights) and 94112 (Ingleside-Excelsior/Crocker-Amazon), and over half reside within six of the City's zip codes (94110, 94112, 94134, 94122 and 94124). St. Francis Wood/Miraloma/Seaside (94127) also has a large proportion (22.3%) of its population under age 18. The proportion of children and youth under age 18 in the zip code areas ranges as high as 32% in Bayview-Hunters Point (94124) and 28% in Visitacion Valley (94134) to as low as 6% in the Rincon/Telegraph Hill/Embarcadero (94111/04/05) area. (Refer to the Appendix for more detailed data and a description of the CACI dataset.)

**English Proficiency.** Enrollment and demographic data on San Francisco Unified School District (public school) students provides another way to estimate the size and identify the characteristics of the children and youth population in San Francisco including English proficiency. Refer to the "Education" section of this report for public school enrollment and demographic data.

## Socioeconomic Conditions

Poverty and socioeconomic conditions are important components of any assessment of children's health because they have been shown to be associated with many types of poor health outcomes, poor nutrition, lack of access to adequate health care, and greater exposures to many kinds of physical, social, environmental, and behavioral risks. While individuals may define "poverty" in a number of ways, the federal Department of Health and Human Services (DHHS) defines poverty within a set of guidelines it issues annually which are widely recognized and used as a standard definition for poverty in the U.S. The guidelines are used for administrative purposes to determine financial eligibility for Federal assistance programs, although many non-Federal agencies also refer to the guidelines.<sup>2</sup> (Refer to the Appendix for the 1998 DHHS Poverty Guidelines.)

**Poverty.** In 1993, an estimated 22% of San Francisco's children and youth under age 18 were in poverty, slightly lower than the statewide (26.4%) or national (22.7%) rate. Poverty rates for children and youth have risen since 1989 at the county, state and national levels. There are no neighborhood-level (sub-county) measures of the child poverty rate since the 1990 Census. (Refer to the Appendix for the 1998 poverty guidelines issued by the U.S. Department of Health and Human Services.)



Poverty is disproportionately concentrated among children, with the rate of poverty among children significantly higher than the rate of poverty in the overall population. In 1993, the poverty rate for San Franciscans of all ages was 13.5% compared to 22% for San Franciscans under age 18. Statewide, the rate for all ages was 17.4% compared to 26.4% for children under age 18.

In 1996, the poverty rate for individuals of all ages nationwide was 13.7% compared to 20.5% for children under age 18 and 17.9% for youth ages 18 to 24 (11.4% for adults ages 18 to 64, and 10.8% for seniors age 65 and over).

For the U.S. as a whole, the risk for being in poverty in 1996 was greater for children under age 6 than for all children under age 18. In addition, the risk of poverty was nearly six times as great for families

<sup>2</sup> The DHHS guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare statistical estimates of the number of persons and families in poverty.

**Persons and Families in Poverty,  
By Selected Characteristics,  
U.S., 1996**

<u>Characteristic</u>	<u>% in Poverty</u>
All Persons	13.7%
Persons By Age Groups	
Under 18 Years	20.5%
18 to 24 Years	17.9%
Persons In Families	
All Ages	12.2%
Related Children Under 6	22.7%
Related Children Under 18	19.8%
Unrelated Children Under 18	46.9%
Families By Type	
Female Householder (Single Parent)	32.6%
Two-Parent	5.6%

Source: U.S. Census Bureau. "Persons and Families in Poverty By Selected Characteristics: 1995 and 1996" (based on March 1997 Current Population Survey), obtained on-line May 10, 1998, at [www.census.gov/hhes/poverty/poverty96/pv96est1.html](http://www.census.gov/hhes/poverty/poverty96/pv96est1.html)

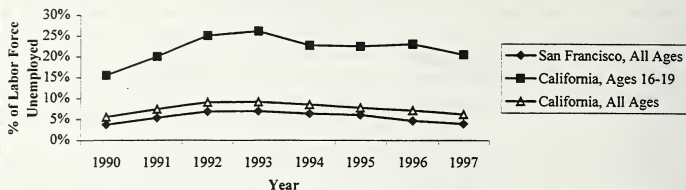
in single-parent female-headed households as compared to two-parent households. (1996 state and county level poverty data not available.)

**Unemployment.** Unemployment rates are commonly used as one of the key indicators of the economic status of a communities. In 1997, San Francisco had the seventh lowest unemployment rate among California counties with an unemployment rate of 4.0%, well below the statewide average of 6.3%.<sup>3</sup> The unemployment rate is the number of unemployed people as a percentage of the labor force.<sup>4</sup> Statewide, unemployment for youth ages 16 to 19 has generally been about three times higher than the unemployment rate among adults ages 20 and over. In 1997, youth unemployment in California declined for the fourth consecutive year, from a peak in 1993 of 26.2% to 20.6% in 1997, which

<sup>3</sup> State and county unemployment rates are annual average rates and are not seasonally adjusted.

<sup>4</sup> For purposes of calculating the unemployment rate, unemployed people are defined as those individuals ages 16 and over who are not working but are able, available, and looking for work (e.g., it does not include those who may be able to but have given up looking for work). It excludes individuals in the military or those who are institutionalized such as in prisons and in mental or physical health facilities.

### Unemployment Rates, By Age Groups, San Francisco and California, 1990-1997



Source: U.S. Department of Labor, Bureau of Labor Statistics (based on Current Population Survey)

followed the statewide and county trends for all age groups (from 9.2% in 1993 to 6.3% in 1997 for the state and from 7.0% in 1993 to 4.0% in 1997 for San Francisco). Unemployment rates for youth are not available at county level. (Refer to the Appendix for more detailed data.)

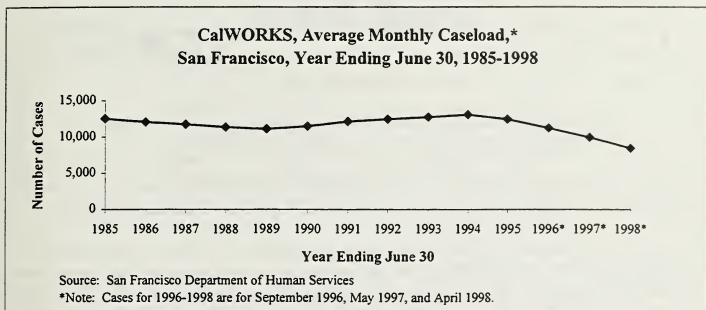
**CalWORKS.** Means-tested entitlement programs are available to all who meet need or resource-based eligibility criteria. They can be useful proxy indicators to track the magnitude and direction of poverty in the population. However, because a number of factors may affect whether the eligible population successfully enroll and access program services, caution must always be exercised when using entitlement program enrollment data since the data cannot always be used as a comprehensive indicator of the underlying social condition the program is addressing.

Enrollment in the Aid to Families with Dependent Children (AFDC) entitlement program was commonly used in the past to gauge the poverty status of children and families. However, the federal Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) eliminated AFDC and replaced it with Temporary Assistance for Needy Families (TANF). PRWORA, or “welfare reform,” created block grants for states to provide time-limited cash assistance for needy families, with work requirements for most participants. Generally, TANF participants must be working within 18 to 24 months and have a five-year lifetime benefit limit. Furthermore, PRWORA gave states enormous flexibility to design their TANF programs.

California’s TANF program is called California Work Opportunity and Responsibility to Kids or CalWORKS. CalWORKS provides counties with flexibility in designing and implementing the program at the local level. San Francisco’s CalWORKS program began on April 6, 1998. Since CalWORKS five-year lifetime clock began on January 1, 1998, it is premature to assess whether program enrollment can continue to be a reliable indicator of poverty, because the impact of CalWORKS rules on enrollment over the next several years is still unknown. Moreover, under CalWORKS, children (designated as dependents on the case) are not subject to the five-year limit, unlike the head of household (parent) on the case. If parents reach the mandated five-year lifetime benefit limit, dependent children may still continue to receive aid, as CalWORKS children-only cases, if need exists until the child is age 18. In this way, CalWORKS is meant to provide a safety net for children to

receive aid even if their parents do not qualify. States also have a 20% hardship allowance on caseloads to continue cases beyond five years without penalty from the federal government.<sup>5</sup>

As of April 1998, there were 8,452 CalWORKS cases in San Francisco, representing a 15% drop compared to May 1997 (9,987 cases). This represents the fourth consecutive year that caseloads

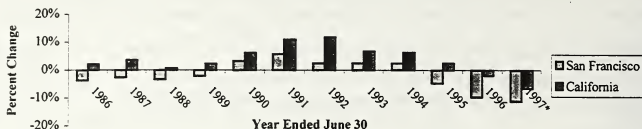


have declined, by 35% since 1994 (13,091). (Refer to the Appendix for detailed data.)

Statewide, CalWORKS caseloads are also declining, although less dramatically than in San Francisco. The number of statewide cases in 1997 was 8% less than in 1995. (Statewide data for 1998 not available. Refer to the Appendix for detailed data.) Both local and statewide declines in caseload

<sup>5</sup> The CalWORKS program arranges for other public benefits during the eligibility process. Medi-Cal assistance is automatically issued to anyone determined to be CalWORKS eligible. Eligibility for Food Stamps, which provides coupons to be redeemed at grocery stores for food purchases, is determined for each CalWORKS case. As a result of federal welfare reform, many immigrants lost their Food Stamps benefits due to mandates that non-citizens no longer qualify. In response, the State of California created state-funded Food Stamp program for children (ages birth to 17) and the elderly for Fiscal Year 1997/98 which will be expanded in Fiscal Year 1998/99.

**CalWORKS, Percent Change in Average Monthly Caseload,\*  
San Francisco and California, Year Ending June 30, 1986-97**



Source: San Francisco Department of Human Services; California Department of Social Services

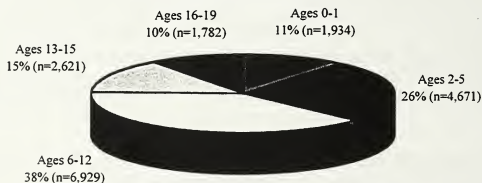
\*Note: San Francisco cases for 1996 to 1997 are for September 1996 and May 1997.

mirrors a national trend. Reasons for the decline in San Francisco include both economic recovery and the exodus of low-income residents from the City because of a lack of affordable housing.<sup>6</sup>

In May 1997, there were 9,942 CalWORKS cases, representing 27,727 individual recipients. Typically, about 80% of CalWORKS cases in San Francisco are single-parent families and about 20% are two-parent families in which the principal wage earner is unemployed. About 90% of single-parent families on CalWORKS in San Francisco are headed by women. In May 1997, 65% (17,937) of recipients were children up to age 19 and 35%; (9,790) were caregivers ages 16 and over.

Among child recipients, were age 5 or younger, 39% were ages 6 to 12, and 25% were ages 13 to 19.

**CalWORKS Recipients, Ages 0-19, By Age Groups,  
San Francisco, May 1997**



Source: San Francisco Department of Human Services, San Francisco TANF Snapshot Quarterly Report: All Households, September 1996-January 1998

Among caregivers, 3% (299) were ages 16 to 19 and 27% (2,667) were ages 20 to 29. The remaining 70% caregivers were age 30 and above, including 7% (701) who were age 50 or above. (Refer to the Appendix for detailed data.)

<sup>6</sup> The Mayor's Welfare Reform Task Force: Final Report, May 1997

About half (49%) of CalWORKS cases were families with one child, 28% had two children, and 21% had three or more children.

<b>CalWORKS, Number of Cases By Family Size, San Francisco, May 1997</b>		
<u>Family Size</u>	<u>#</u>	<u>%</u>
Families w/ 1 Child, Unborn	198	2%
Families w/ 1 Child	4,869	49%
Families w/ 2 Children	2,827	28%
Families w/ 3 Children	1,286	13%
Families w/ 4-6 Children	728	7%
Families w/ 7+ Children	34	<1%
Total Families	9,942	100%
Source: San Francisco Department of Human Services, <u>San Francisco TANF Snapshot: Quarterly Report: All            Households, September 1996-January 1998</u>		

Over half (54%) of San Francisco's CalWORKS families lived within five neighborhoods including Bayview-Hunters Point, Mission, Visitacion Valley, Ingleside/Excelsior, and Tenderloin. (Refer to the Appendix for more detailed data.)

<b>CalWORKS, Cases By "Top 5" Zip Codes, San Francisco, May 1997</b>		
		Cases
<u>Zip Code</u>	<u>Neighborhood</u>	<u>#</u> <u>%</u>
94124	Bayview/Hunters Point	1,755      17.6%
94110	Mission	1,181      11.8%
94134	Visitacion Valley	945      9.5%
94112	Ingleside/Excelsior	896      9.0%
94102	Tenderloin	622      6.2%
-	All Others	4,588      45.9%
	TOTAL	9,987      100.0%
Source: San Francisco Department of Human Services, <u>San Francisco TANF            Snapshot Quarterly Report: All Households, September 1996-January 1998</u>		

## EDUCATION

The extent of one's knowledge and the ability to think, learn, and communicate affects a person's ability to function well in many aspects of society. Formal education aims to provide individuals with knowledge and skills to prepare them to be contributing, aware, and discerning adult citizens. Completion of basic and advanced levels of education is correlated with greater likelihood of life success in employment and economic self-sufficiency, family parenting capacity, and participation in civic activities.

Schools are the institutions in which children and youth from age 6 to 18 receive their formal education and spend a significant portion of their time. Schools are where children and youth can be observed, be guided by, and develop important relationships with adult educators. Since the inception of the public school, educators, parents, and many others have been concerned about the well-being of schools in terms of their ability to:

- a) Fulfill its educational mission with quantifiable success and at a reasonable cost, and
- b) To support and promote the optimal health of students and staff that will contribute to a healthy and positive school environment.

Educators have long known that for children to be able to succeed in the educational setting, they must have good physical and mental health. In San Francisco, the education of children and youth is offered through a complex set of public and private schools serving young people from infancy to young adulthood.

This section presents an overview of San Francisco student enrollment, demographic, and performance data, mainly in the public school system.

### Data Sources

A majority of the data for this section was obtained from the San Francisco Unified School District (SFUSD), San Francisco's publicly financed school system. SFUSD data was chosen mainly for its accessibility and its ability to describe the majority of young people in San Francisco. In San Francisco, about 75% of school-age children are enrolled in public schools and 25% are in private schools. In California, a much larger population of school-age children (90%) are in public schools. Comparable data is not available for private school enrollees. Data for this section includes:

- Demographic and academic performance data on students enrolled in SFUSD, using a combination of 1996/97 and 1997/98 school year data, for kindergarten through grade 12.
- Enrollment data on the SFUSD's Child Development Program, as of April 1998.
- Enrollment data for the San Francisco Head Start Program for the 1995/96 school year.

### Enrollment in Programs for Young Children

Early childhood development programs can improve a child's social skills, problem-solving abilities self-esteem, and long-term school performance by providing a positive introduction to learning that instills the motivation and the basic skills they need to thrive in the classroom, at home, and later in life.<sup>7</sup> Research has shown that most of a child's crucial brain development occurs during his or her

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<sup>7</sup> U.S. Department of Health and Human Services, Healthy People 2000: National Health Promotion and Disease Prevention Objectives

first three years of life. A child's experiences and environment during this critical period impact his or her lifetime of social, emotional, cognitive, and physical development. High quality early childhood development programs have an impact precisely at the point when children's development is rapid and dramatic. Quality is the critical variable affecting outcome for the child, not the setting of the child development program such as family day care home, community center, or school.

San Francisco has an array of early care and education programs that are funded by a complex mix of private and public sources. Despite the availability of these programs, San Francisco has not yet achieved the Healthy People 2000 objective (8.3) that all disadvantaged children and children with disabilities have access to high quality and developmentally appropriate preschool programs. These programs would help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health.<sup>8</sup> In addition to providing an overview of child care availability in the City, this section will briefly describe two key publicly-funded early childhood education programs in the City, the SFUSD's Child Development Program and San Francisco Head Start.

Child Care. Parents and early care and education providers are jointly raising many of San Francisco's youngest children. In San Francisco, over half (about 25,000) of children age 5 and younger are estimated to live in households where either both parents or the single parent head-of-household is in the labor force. About half of these children (12,717) are in child care outside the family.<sup>9</sup>

In 1997, there were over 17,500 child care slots in the City including slots in licensed child care centers (13,569 slots) and licensed family child care homes (3,993). Data on the number of children in these slots is not tracked in any centralized manner. However, the demand for affordable child care relative to availability is considered high in the City, particularly for infant care.<sup>10</sup>

There is a critical shortage in the number of child care slots per young child receiving public assistance, which has important implications for the ability of parents on public assistance to fulfill the work requirements accompanying welfare reform. For a more in-depth review of the availability and need for child care in San Francisco, especially in relation to welfare reform, we refer readers to several resources.<sup>11</sup>

Child Development Program. The San Francisco Unified School District's Child Development Program (CDP) is the largest provider of early childhood education programs for San Francisco's young children. CDP's infant/toddler and pre-kindergarten programs help young children beginning at infancy to improve their school readiness; kindergarten through fifth grade afterschool and summer programs help to enhance and enrich children's social, emotional, and academic life.

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<sup>8</sup> This Healthy People 2000 objective, developed by the U.S. Department of Health and Human Services, is consistent with the National Education Goals developed by the U.S. Department of Education.

<sup>9</sup> The California Child Care Resource and Referral Network. The California Child Care Portfolio. 1997

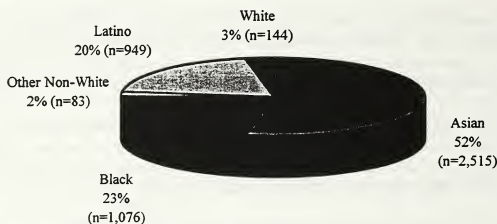
<sup>10</sup> The California Child Care Resource and Referral Network. The California Child Care Portfolio. 1997

<sup>11</sup> California Department of Education, Ready to Learn: Quality Preschools for California in the 21<sup>st</sup> Century – The Report of the Superintendent's Universal Preschool Task Force, Sacramento, 1998; Yale University, Bush Center for Child Development and Social Policy, Not By Chance: Creating an Early Care and Education System for America's Children, New Haven, 1997; The California Child Care Resource and Referral Network, The California Child Care Portfolio, 1997; Children's Defense Fund, Locked Doors: States Struggling to Meet the Child Care Needs of Low-Income Working Families, Washington, D.C., 1998.

The CDP operates at 45 sites throughout the City, with a total monthly enrollment averaging 4,700 children. This includes approximately 1,450 infants, toddlers, and pre-kindergarten children up to age 4 and about 3,200 children from kindergarten through fifth grade. Families are eligible based on income and other criteria. Some CDP programs are available at no cost, and others are available on a sliding-fee scale basis.

As of April 1998, over 95% of the CDP's enrolled students were racial/ethnic minorities, with Asians comprising over half of all enrolled children. Asian subgroups included 2,430 Chinese, 46 Filipino, 27 Southeast Asian, 10 Korean, and 2 Japanese.

**San Francisco Unified School District, Child Development Program,  
Enrollment By Ethnicity, April 1998**



Source: SFUSD Child Development Program, May 1998

**Head Start Program.** Child development programs for low-income pre-schoolers can foster positive attitudes towards school, enhance school performance, and increase high school graduation rates. One of the best known early childhood development programs is Head Start, a federally-funded program administered by local agencies that addresses the social, health, and educational needs of preschool children ages 3 to 5 from low-income families. The primary goal of Head Start is to increase school readiness and early school success of children who come from educationally disadvantaged backgrounds. Head Start is a well-researched program with documented effectiveness continuing over time including enhanced school achievement during participants' early school and higher high school graduation rates much later.

In the 1995-96 program year (the most recent year for which data are available), San Francisco Head Start Program was comprised of 14 centers serving a total of 1,074 San Francisco children, in addition to providing home-based services to 87 families.<sup>12</sup> (Refer to the Appendix for a map of Head Start sites in the City.)

<sup>12</sup> Economic Opportunity Council, E.O.C. Head Start Community Needs Assessment, January 1, 1995

### Demographics of SFUSD Students

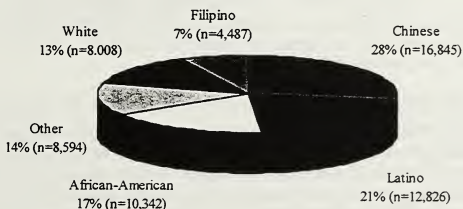
The SFUSD serves children and youth from kindergarten through grade 12. The mission of the SFUSD is “to provide each student with an equal opportunity to succeed by promoting intellectual growth, creativity, self discipline, cultural and linguistic sensitivity, democratic responsibility, economic competence and physical and mental health so that each student can achieve to his or her maximum ability.” Demographic data on SFUSD students provides some indication of the size and characteristics of the school-age population in San Francisco, roughly ages 6 to 18. In San Francisco, about 75% of school-age children are enrolled in public schools and 25% are in private schools. In California, a much larger proportion of school children (90%) are in public schools.

In the 1996/97 school year, there were 61,503 students enrolled in SFUSD. This compares to 30 years ago when SFUSD had close to 94,00 students enrolled. The decline in enrollment was steady for the late 1960’s until the early 1980’s when it stabilized in the low 60 thousands. Total SFUSD enrollment in 1997/98 dropped slightly, to 61,011 students.

By Gender. In 1997/98, there were slightly more male (51.2%) than female (48.8%) students.

By Race/Ethnicity. The SFUSD population is racially/ethnically diverse. In 1996/97, over one-fourth (28%) of SFUSD students were Chinese, 21% were Latino, 17% were African-American, 13% were

**San Francisco Unified School District Enrollment,  
By Race/Ethnicity, 1996/97**



Source: San Francisco Unified School District

White, 7% were Filipino, and 14% were “Other.” (Refer to the Appendix for 1997/98 enrollment data by race/ethnicity.) The most notable difference between the City’s child and youth population and the SFUSD population is the smaller proportion of White children and youth in SFUSD compared to their proportion in the City’s population.

By Zip Code. In 1996/97, over half (52%) of SFUSD students resided in five City zip code areas. The top nine zip codes accounted for nearly three-fourths of SFUSD enrollees. (Refer to the Appendix for more detailed data.)

**San Francisco Unified School District,  
Enrollment and Limited and Non-English Status,  
"Top 10" Zip Codes, 1996/97**

Zip Code	Area	Enrollment		Limited/No English	
		# of Students	% of Total	# of Students	% Within Zip Code
94112	Ingleside-Excelsior	8,170	13.3%	2,941	36.0%
94110	Inner Mission	7,876	12.8%	3,711	47.1%
94134	Visitacion Valley-Portola	5,181	8.4%	1,639	31.6%
94122	Sunset	4,677	7.6%	1,229	26.3%
94133	North Beach/Chinatown	2,093	3.4%	1,134	54.2%
94109	Polk Gulch-Russian Hill	2,168	3.5%	1,114	51.4%
94116	Parkside	4,003	6.5%	1,082	27.0%
94121	Outer Richmond	4,554	7.4%	1,080	23.7%
94124	Bayview-Hunter's Point	6,287	10.2%	950	15.1%
94103	South of Market	1,619	2.6%	806	49.8%
	Other Zip Codes	14,875	24.2%	3,398	17.8%
	TOTAL*	61,503	100.0%	19,084	31.0%

Source: San Francisco Unified School District

English Proficiency. Large numbers of San Francisco young people are designated as either Limited English Proficient (LEP) or Non English Proficient (NEP), based on oral language and literacy tests. These are students who have been determined to lack the English language skills including listening comprehension, speaking, reading, and writing to succeed in the school's regular instructional programs. These children present a particular challenge to the SFUSD where children come from over 50 different and distinct language groups.

In 1996/97, over 30% of SFUSD students (19,084) spoke limited English (26.4%), or were non-English speaking (4.6%). Ten zip code areas in the City represented 82% (15,686) of all LEP/NEP students in San Francisco public schools. (Refer to the table above.) The percentage of SFUSD students who were LEP or NEP in 1997/98 was slightly higher at 33.2% (20,266) (1997/98 LEP/NEP data by zip code not available).

The largest number of LEP/NEP students were from the Inner Mission area. However, other areas had larger percentages of LEP/NEP students including Chinatown, North Beach/Chinatown, and Polk

Gulch/Russian Hill areas where over half of students in each of these areas were LEP or NEP. (Refer to the Appendix for detailed data.)

1997/98 enrollment data indicates that the students in the earliest grade levels have the greatest number and proportion of LEP or NEP students.

**Students With Limited and Non-English Proficiency,  
San Francisco Unified School District,  
By Grade Level, 1997/98**

<u>Grade Level</u>	<u># of Students</u>	<u>% in Grade Level</u>
K-5	11,723	43.6%
6-8	3,332	27.2%
9-12	4,524	23.9%
Total	20,266*	33.2%

Source: San Francisco Unified School District, San Francisco Unified School District School Profiles, 1997-98, obtained on-line on May 4, 1998 at [www.orb.sfusd.k12.ca.us/profile](http://www.orb.sfusd.k12.ca.us/profile)

\*Note: Includes 687 "other" students.

### **Enrollment in Programs That Enhance Learning**

Several federally or state funded programs including the School Lunch Program and programs for special education and severely emotionally disturbed students augment the educational enterprise in the SFUSD.

**School Lunch Program.** The School Lunch Program is one program offering a perspective on the health of children as they come to school. The program is a federally funded, means-tested entitlement available to all qualifying children attending schools in districts participating in the program, which includes SFUSD. Eligibility for free or reduced-price lunches in the School Lunch Program is based on family income below 100% and about 142% of federal poverty level, respectively. In 1996/97, 14,853 or about one-quarter (24%) of San Francisco's public school children were found to be eligible for free or reduced-priced lunches through the School Lunch Program.

Five zip code areas in the city represented 58% of students receiving free or reduced school lunches. Bayview-Hunter's Point (94124) had the largest number of students who were participating in the program. Bayview Hunter's Point and the Western Addition (94115), had the highest percentage - over 37% of SFUSD students from the area were participating in the program. For zip codes with at

**San Francisco Unified School District,  
School Lunch Enrollment,  
"Top 10" Zip Codes, 1996 /97**

<u>Zip Code</u>	<u>Area</u>	Total	School Lunch	
		Enrollment	#	%
94124	Bayview-Hunter's Point	6,287	2,336	37.2%
94110	Inner Mission	7,876	2,032	25.8%
94112	Ingleside-Exelsior	8,170	1,829	22.4%
94134	Visitacion Valley	5,181	1,513	29.2%
94121	Outer Richmond	4,554	901	19.8%
94115	Western Addition	1,927	728	37.8%
94109	Polk/Russian Hill	2,168	680	31.4%
94102	Tenderloin	1,975	670	33.9%
94122	Sunset	4,677	627	13.4%
94118	Inner Richmond	2,505	611	24.4%
-	Other	16,183	2,926	18.1%
<b>TOTAL</b>		<b>61,503</b>	<b>14,853</b>	<b>24.2%</b>

Source: San Francisco Unified School District

least 1,000 students, the percentage of SFUSD students participating in the program ranges from 38% for Western Addition (94115) to about 7% for St. Francis Wood/Seaside (94127). (Refer to the Appendix for detailed data.)

Special Education and Severely Emotionally Disturbed. SFUSD provides two types of programs to assist children who need special help in achieving success in the classroom due to either learning disabilities or emotional issues that interfere with the learning process. Profiles of these students suggest the extent of learning difficulties that children present when coming to SFUSD schools.

In 1997/98, a total of 5,326 students were enrolled in special education or 8.7% of all SFUSD students. Special education students are "individuals with exceptional needs" who have been identified as having disabilities such that their impairment requires instruction, services, or both which cannot be provided with modification of the regular school program.

**San Francisco Unified School District,  
Special Education Students,  
By Grade Level, 1997/98**

<u>Grade Level</u>	<u># of Students</u>	<u>% of Grade Level</u>
K-5	2,000	7.4%
6-8	1,456	11.9%
9-12	1,560	8.2%
Total	5,326	8.7%

Source: San Francisco Unified School District, San Francisco Unified School District School Profiles, 1997-98, obtained on-line on May 4, 1998 at [www.orb.sfusd.k12.ca.us/profile](http://www.orb.sfusd.k12.ca.us/profile)

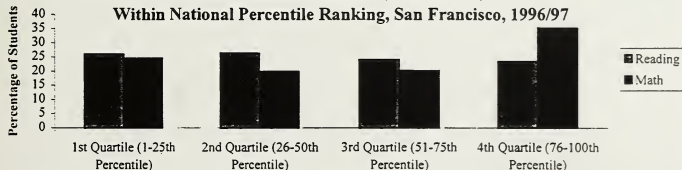
The SFUSD is also mandated to provide education for children identified as Severely Emotionally Disturbed (SED). These children receive special classroom placement and additional support services. Refer to the "Mental Health" section of this report for a review of SED students in SFUSD.

### Performance Measures

**CTBS.** SFUSD students from grades 1 through 11 are tested using the Comprehensive Test of Basic Skills (CTBS). The CTBS is a test designed to measure achievement in the basic skills taught in schools throughout the nation. The subject areas measured are reading, language, spelling, mathematics, math, science, and social studies.

The highest possible score on the CTBS is 99; 50 is the national average. In 1996/97, SFUSD students as a whole ranked slightly lower (48<sup>th</sup> percentile) than the national norm for reading and slightly higher (56<sup>th</sup> percentile) than the national norm for math.

**Comprehensive Test of Basic Skills, Percentage of San Francisco Unified  
School District Students (Grades 1-11)  
Within National Percentile Ranking, San Francisco, 1996/97**

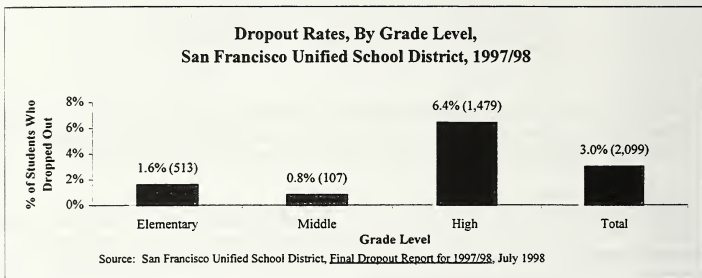


Source: San Francisco Unified School District

Students scoring below the 40% percentile on the CTBS in math and/or reading (one subject or both) are identified as being Educationally Disadvantaged Youth (EDY). In 1996/97, 22,036 or 36.1% of SFUSD students were identified as EDY.

Graduation/Dropout Rate. Dropping out of school is associated with later unemployment, poverty, and poor health. During adolescence, dropping out of school is associated with multiple social and health problems including substance abuse, delinquency, intentional and unintentional injury, and unintended pregnancy.<sup>13</sup>

In 1997/98, 6.4% (1,479) of high school students in SFUSD dropped out by the end of the school year. The dropout rate for the entire SFUSD population was 3.0% (2,099). San Francisco (within the public school system) has exceeded the Healthy People 2000 objective (8.2) to increase the high school graduation rate to at least 90%.<sup>14</sup>

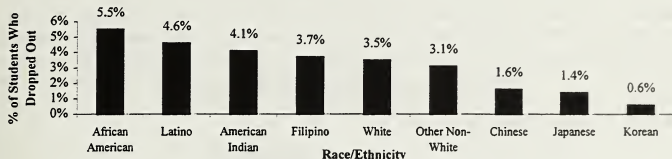


In 1997/98, African Americans had the highest dropout rate (5.5%) and comprised 25.9% (543) of all SFUSD students who dropped out during the school year. Latinos had the second highest dropout rate (4.6%) among SFUSD students and comprised the largest number (592) of SFUSD students who dropped out (28.2%).

<sup>13</sup> U.S. Department of Health and Human Services, Healthy People 2000: National Health Promotion and Disease Prevention Objectives

<sup>14</sup> This Healthy People 2000 objective, developed by the U.S. Department of Health and Human Services, is consistent with the National Education Goals developed by the U.S. Department of Education.

### Dropout Rates, By Race/Ethnicity, San Francisco Unified School District, 1997/98



Source: San Francisco Unified School District, Final Dropout Report for 1997/98, July 1998

The proportion of drop outs who were Filipino and White was roughly proportional to their percentage in the SFUSD population. Filipinos represented 8% of dropouts and 7% of the SFUSD population; Whites represented 12.5% of dropouts and 13% of the SFUSD population. Chinese students represented a much smaller proportion of dropouts (13%) compared to their representation in the SFUSD population (28%).<sup>15</sup> (Refer to the Appendix for detailed data.)

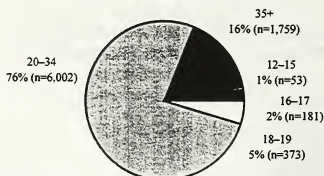
<sup>15</sup> These are the race/ethnicity categories designated by SFUSD.

## PERINATAL HEALTH

### Births

In 1996, there were a total of 8,368 live births in San Francisco. Three-fourths (76%) of these births were to women ages 20 to 34. Births to adolescents (ages 12 to 19) totaled 607 or 8% of all births, with older adolescents ages 18 to 19 representing a majority (373) of births to adolescents.<sup>16</sup> The total number of births among San Francisco women declined by 15% from 1991 (9,893 births) to 1996. (Refer to the Appendix for detailed data.)

**Live Births, By Mother's Age,  
San Francisco, 1996**



Source: San Francisco Department of Public Health, Birth Certificates

Women of childbearing age (ages 15 to 44) in San Francisco are giving birth at much lower rates (49.8 live births per 1,000) than their statewide counterparts (79.4). San Francisco's relatively older population also contributes to the low birth rate per 1,000 population (12.0) in the City compared to the statewide rate (17.4).

**Birth Rate and Fertility Rate,  
San Francisco and California**

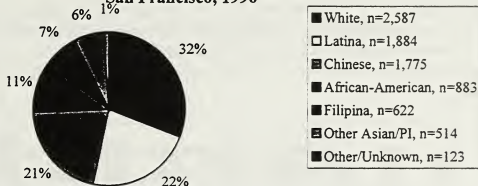
	San Francisco	California
Birth Rate (Live Births Per 1,000 Population) (1994)	12.0	17.4
Fertility Rate (Births Per 1,000 Women Ages 15-44) (1992-1994 average)	49.8	79.4

Source: California Department of Health Services, Health Data Summaries  
for California Counties, 1996

<sup>16</sup> The terms "adolescents" and "teens" are often used interchangeably to refer to young mothers through age 19.

**By Race/Ethnicity.** In 1996, over two-thirds of all births in San Francisco were to women of racial/ethnic minorities. Whites accounted for the largest proportion (32%) of births. Births to Latina (22%), Chinese (21%), and African-American (11%) mothers combined accounted for over half of all births in the City.

**Live Births, By Mother's Race/Ethnicity,  
San Francisco, 1996**



Source: San Francisco Department of Public Health, Birth Certificate Records

**By Zip Code.** In 1996, 70% of women who gave birth were from among ten zip codes in the City. There were over 1,000 births each within the two top zip codes, Inner Mission/Bernal Heights (94110) and Ingleside-Excelsior/Crocker-Amazon (94112). (Refer to the Appendix for detailed data.)

**Live Births - "Top 10,"  
By Mother's Residence Zip Code,  
San Francisco Residents, 1996**

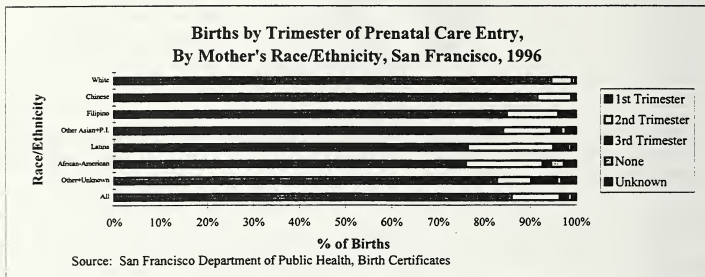
Zip Code	Area	Total	
		#	%
94110	Inner Mission/Bernal Hts.	1,124	13.4%
94112	Ingles'-Excelsior/Crocker-Amazon	1,098	13.1%
94134	Visitacion Valley/Sunnydale	567	6.8%
94122	Sunset	564	6.7%
94124	Bayview-Hunter's Point	538	6.4%
94116	Parkside	452	5.4%
94121	Outer Richmond	436	5.2%
94109	Polk/Russian Hill	414	4.9%
94118	Inner Richmond	377	4.5%
94115	Western Addition/Japantown	298	3.6%
-	All Other Areas	2,500	29.9%
-	Total	8,368	100.0%

Source: San Francisco Department of Public Health, Birth Records

### Entry into Prenatal Care

Late prenatal care (in the second or third trimester) is considered a risk factor for worse birth outcomes including low birth-weight and infant mortality. Poverty, poor education, and unmarried status are associated with lack of access to or use of prenatal care. In 1996, 86% of all births in San Francisco were to women who received early prenatal care (in the first trimester of pregnancy). This rate is close to achieving the Healthy People 2000 objective that 90% of all pregnant women receive early prenatal care.

**By Race/Ethnicity.** In the same year, African-Americans and Latinas both experienced the lowest rate (76%) of first trimester prenatal care compared to women of other race/ethnicities. Latinas were more likely to receive late prenatal care (3.2%; 61) than none at all (0.7%; 14), while African American women were more likely to receive no prenatal care (3%; 24) than prenatal care beginning in the third trimester (2%; 17).



Pacific Islanders, grouped within "Other Asian", represented a small percentage of the total number of births (1%; 87). Only 59% of Pacific Islander women (51) obtained early prenatal care. One-fourth (26%; 23) received late prenatal care in the second trimester, 8% (7) received prenatal care in the third trimester, and 2.3% (2) received no prenatal care at all (4 unknown).

**Trends.** Citywide, early entry into prenatal care improved, from 79% of all births in 1992 to 86% in 1996. Rates for African-Americans and Latinas are also improved, from 64% to 76% for African-Americans and from 68% to 76% for Latinas.

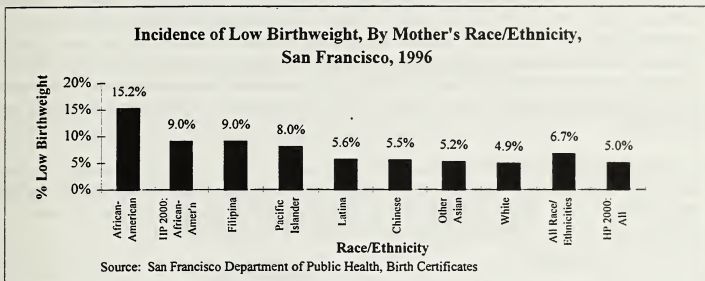
At the same time, combined rates of late prenatal care (third trimester entry) and no prenatal care citywide decreased from 1992 to 1996, from 5% to 2.5% for all race/ethnicities except for Pacific Islanders (from 9% to 10%). African-American and Latina rates of late and no prenatal care decreased, from 12% to 5% for African-Americans and from 6% to 4% for Latinas.

### Low Birthweight

Birthweight serves as a marker for health status of infants. Low birthweight infants (under 2500 grams or 5.5 pounds) are at a higher risk for physical and developmental complications (morbidity) and infant

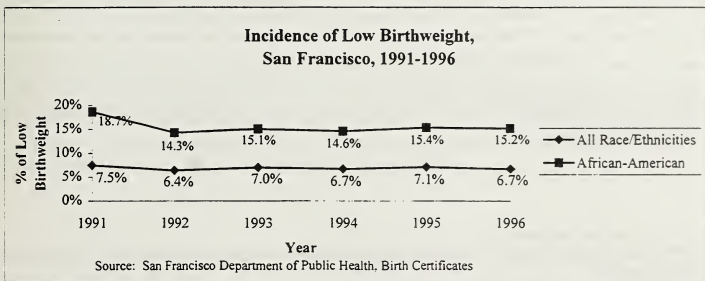
mortality. Low birthweight is associated with late or no prenatal care, poor maternal nutrition, maternal smoking, preterm delivery, and other conditions.

In 1996, there were 560 low birthweight births in San Francisco, representing 6.7% of all births in the City. African-American women had the highest rate, 15.2% of births. Filipinas and Pacific Islanders had the second (9.0%) and third (8.0%) highest. Latinas (5.6%), Chinese (5.5%), and "Other Asians" (5.2%) had low birthweight rates which were less than the citywide average. Whites, at 4.9%, had the lowest rate of low birthweight of all ethnic groups in the City.



San Francisco is unlikely to attain the Healthy People 2000 objectives of reducing low birthweight to no more than 5% of live births overall and no more than 9% for African-Americans without a substantial reduction in the number of low birthweight infants born to African-Americans.

In 1996, the incidence of low birthweight citywide (6.7%) was nearly a percentage point lower than the rate in 1991(7.5%). The low birthweight rate for African-Americans over the six-year period was disproportionately high, at over twice the citywide rate, ranging from 14.3% to 18.7% of births. While African-American rates did decline from 1991 to 1996 from 18.7% to 15.2%, all of that improvement came in the first year, from 1991 to 1992, with little change since then.



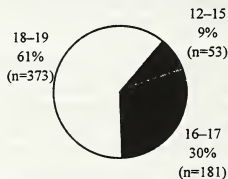
### **Births to Adolescents**

Adolescent childbearing has important health and social consequences for young women, their babies, and their families. Many adolescent mothers are not ready for the emotional, psychological, and financial responsibilities and challenges of parenthood. Pregnant adolescents are more likely to have no health insurance coverage and to have inadequate prenatal care. The younger the adolescent mother, the more likely she is to have poor pregnancy outcomes such as preterm delivery and a low birthweight infant.

Later in life, adolescent mothers are more likely to experience marital instability, lower educational attainment, and poor socioeconomic status. Children born to adolescent mothers are less likely to complete high school and to be financially independent of public assistance, and are more likely to get pregnant during adolescence. Maintaining a low rate of births to adolescents can be accomplished through the combined effect of school-based family life education programs, adequate and accessible reproductive health care services, and social support services addressing adolescent pregnancy and parenting.

In 1996, there were 607 births to adolescents ages 12 to 19, representing 7.3% of all births (8,368) in the City.<sup>17</sup> San Francisco's percentage of births to adolescents was notably lower than the statewide rate (1995) of 12%.<sup>18</sup> Nearly two-thirds (61%) of births to adolescents in San Francisco were to mothers ages 18 to 19, 30% were to ages 16 to 17, and 9% were ages 12 to 15.

**Live Births to Adolescents, Ages 12-19,  
San Francisco, 1996**



Source: San Francisco Department of Public Health, Birth Certificates

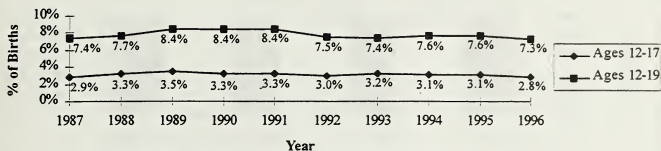
San Francisco has set as an objective to reduce births to adolescents to no more than 5% by the Year 2000.<sup>19</sup> Although the percentage of births to adolescents in 1996 was the lowest since 1987, this objective may be difficult to attain. The percentage of births to adolescents has not dropped below 7% in the last ten years.

<sup>17</sup> The Healthy People 2000 objective is to reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents.

<sup>18</sup> California Department of Health Services, Vital Statistics

<sup>19</sup> San Francisco Department of Public Health, Maternal, Child, and Adolescent Health 5 Year Plan, 1996-2001

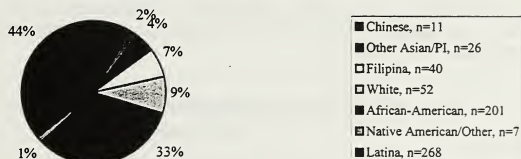
### Percent of Births to Adolescents, Ages 12-19, San Francisco, 1987-1996



Source: San Francisco Department of Public Health, Birth Certificate Records

Latinas and African-Americans represent over three-quarters (77%) of all births to adolescent mothers ages 12 to 19, with 268 births to Latinas and 201 births to African Americans.

### Live Births to Adolescent Mothers, Ages 12-19, By Mother's Race/Ethnicity, San Francisco, 1996

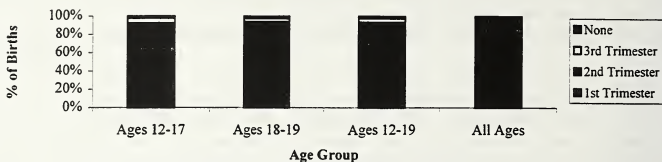


Source: San Francisco Department of Public Health Birth Certificates

**Adolescent Entry Into Prenatal Care.** For many adolescents, the daunting task of facing their pregnancy and their general lack of connection to health care services delays their entry into prenatal care. Adolescent mothers are much less likely than older women to receive timely prenatal care and more likely to have no care at all, and the likelihood of poor access to care is even greater for the school-age mother (ages 12 to 17) than the older adolescent mother (ages 18 to 19).

In 1996, 65% (152) of adolescents ages 12 to 17 and 75% (279) of adolescents ages 18 to 19 years old obtained early prenatal care (during their first trimester). This compares to 87% (6,780) of pregnant women ages 20 and older who received early prenatal care. The level of prenatal care sought by adolescents is far short of the Healthy People 2000 goal of 90%.

### Trimester of Prenatal Care Entry, By Various Age Groups, San Francisco, 1996

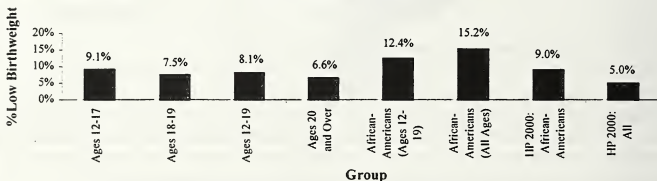


Source: San Francisco Department of Public Health, Birth Certificates

Five percent (12) of adolescent mothers ages 12 to 17 first obtained prenatal care in the third trimester and 2% (5) received no prenatal care at all. Three percent (11) of adolescent mothers ages 18 to 19 first obtained prenatal care in the third trimester and 3% (10) received no prenatal care at all. These rates compare to 2% (124) of third trimester entry and 1% (74) of no prenatal care for women ages 20 and older.

Low Birthweight Among Births to Adolescents. In 1996, 8.1% of all births to San Francisco adolescents (ages 12 to 19) were low birthweight, compared to 6.6% of infants born to San Francisco mothers age 20 or older.

### Incidence of Low Birthweight, By Selected Groups, San Francisco, 1996



Source: San Francisco Department of Public Health, Birth Certificates

The rate of low birthweight infants was higher among younger adolescents ages 12 to 17 (9.1%) compared to older adolescents ages 18 to 19 (7.5%). The rate of low birthweight infants born to African-American adolescents (ages 12 to 19) was substantially higher (12.4%) than the rate for all adolescents, although the rate was lower than the rate for African-American mothers of all ages (15.2%).

San Francisco is making progress in increasing the proportion of pregnant women who seek prenatal care in the first trimester. Adolescents are following suit with improvements from 1994 to 1996 from 61% to 65% for mothers ages 12 to 17 and from 67.5% to 75% for mothers ages 18 to 19.

**Live Births to Adolescents – “Top 10”,  
By Mother’s Zip Code of Residence,  
San Francisco, 1996**

<u>Zip Code</u>	<u>Area</u>	Total	
		#	%
94102	Tenderl'n/Hayes Val./N. of Mkt.	142	23.4%
94103	South of Market	104	17.1%
94107	Potrero Hill	95	15.7%
94108	Chinatown	47	7.7%
94109	Polk/Russian Hill	41	6.8%
94110	Inner Mission/Bernal Hts.	27	4.4%
94112	Ingles'-Excels'r/Crock'r-Amaz'n	23	3.8%
94114	Castro, Noe Valley	18	3.0%
94115	Western Addition/Japantown	17	2.8%
94116	Parkside	17	2.8%
-	All Other Areas	76	12.5%
-	Total	607	100.0%
	% of All Births	7.3%	-

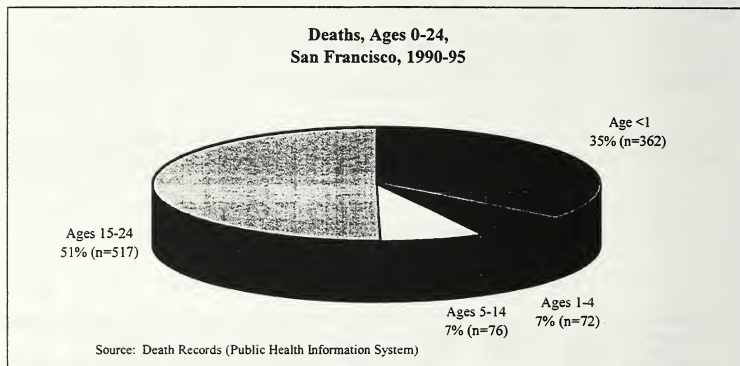
Source: San Francisco Department of Public Health,  
Birth Records

By Zip Code. In 1996, over half (56%) of all births to adolescents were to mothers residing in three zip codes in the City, including 94110 (Inner Mission/Bernal Heights), 94112 (Ingleside-Excelsior/Crocker-Amazon), and 94124 (Bayview-Hunter’s Point). (Refer to Appendix for detailed data.)

## MORTALITY

This section reviews deaths occurring over a six-year period, from 1990 through 1995, among children and youth from birth to age 24. In addition, this section provides data from an additional year, 1996, on infant deaths (less than 1 year old). Because the number of deaths per year among the San Francisco children and youth population is relatively small, reviewing deaths over a multi-year period provides more reliable death rates and also allows for better comparisons by cause of death, age, gender, and race/ethnicity subgroups.

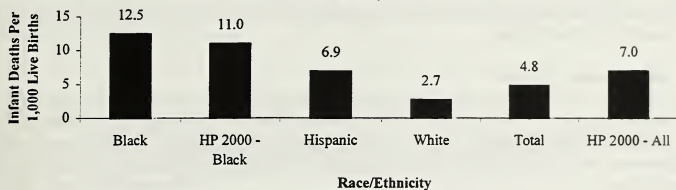
From 1990 to 1995, there were a total of 1,027 deaths of San Francisco children and youth from birth to age 24. About half (51%) of these deaths (517) were in the 15 to 24 age group, and another third (35%) of deaths were among infants (362).



**Infant Mortality.** Infant mortality is an important measure of a community's health and is a universally recognized indicator of health status of a community. In 1996, there were 40 deaths of infants less than 1 year old in San Francisco, representing an infant mortality rate of 4.8 per 1,000 live births. San Francisco has achieved the Healthy People 2000 goal of reducing the infant mortality rate to no more than 7 per 1,000 live births.

In 1996, there were 11 deaths of infants less than 1 year old, representing a rate of 12.5 per 1,000 live births, the highest rate among all race/ethnic groups in the City. This compares to the Healthy People 2000 goal of reducing the infant mortality rate among Blacks to 11.0 per 1,000 live births, although the difference cannot be considered statistically significant since the number of San Francisco Black infant

### Infant Mortality Rate, By Race/Ethnicity, San Francisco, 1996

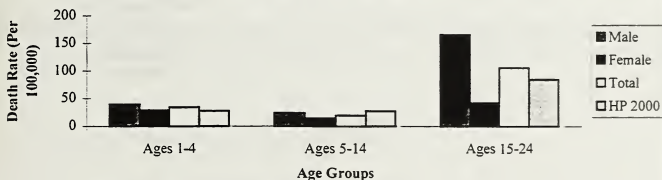


Source: San Francisco County AVSS Birth Records

deaths for the single year is small. The rate for Hispanics was 6.9 (13 deaths) and the rate for Whites was 2.7 (7 deaths).<sup>1</sup> Rates for other race/ethnic groups were not calculated due to the small number of births and/or deaths occurring during the one-year time period.<sup>2</sup> (Refer to the Appendix for more detailed data.)

**Ages 1 to 24.** From 1990 to 1995, males comprised 70% (716) of deaths among children and youth ages 1 to 24 (311 deaths in females). Within all age groups, mortality rates were higher for males than females. The differences between males and females was most pronounced in the 15 to 24 age group, with death rates among males nearly four times the rate of females (166.1 vs. 42.6 per 100,000). Youth ages 15 to 24 had the highest death rates, with death rates for females that were triple the rate for females ages 5 to 14 (42.6 vs. 14.6). Death rates for males ages 15 to 24 were six times higher than the rates for males ages 5 to 14 (166.1 vs. 24.2). (Refer to the Appendix for detailed data.)

### Death Rates (Per 100,000 Population), Ages 1-24, San Francisco, 1990-95



Source: Death Records (Public Health Information System)

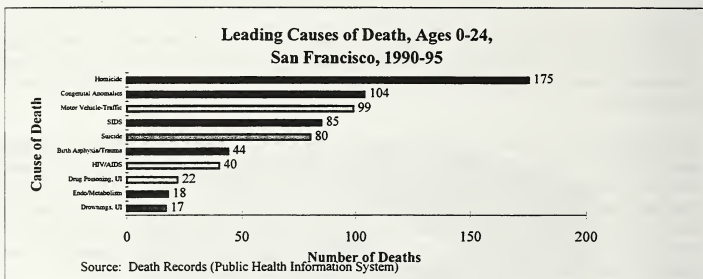
<sup>1</sup> There are no Healthy People 2000 objectives for infant mortality for additional race/ethnic groups other than American Indians/Alaska Natives (8.5 infant deaths per 1,000 live births) and Puerto Ricans (8.0 infant deaths per 1,000 live births).

<sup>2</sup> These are the race/ethnic categories designated by the AVSS Birth Records system (for infant mortality data) and the U.S. Department of Health and Human Services (for Healthy People 2000 goals).

San Francisco's rate of 19.5 per 100,000 for children met the Healthy People 2000 mortality goal of 28 for children ages 5 to 14. San Francisco's rate of 34.6 falls short of reaching the same goal of 28 for children from ages 1 to 4. San Francisco's rate of 106.2 is far short of reaching the Healthy People 2000 goal of reducing the death rate among youth ages 15 to 24 to 85 per 100,000. (Refer to the Appendix for detailed data.)

### Leading Causes of Death

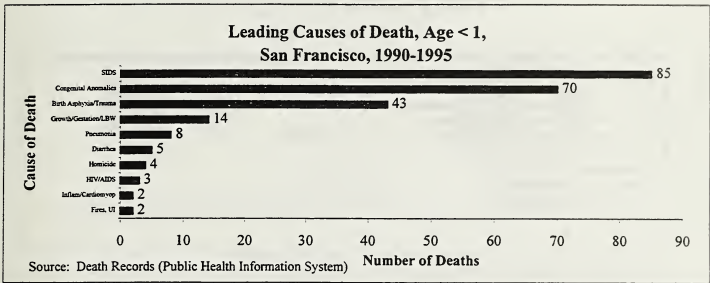
From 1990 to 1995, the ten leading causes of death among the San Francisco children and youth population ages 0 to 24 account for two-thirds (67%) of all deaths in this age group. (Refer to the Appendix for detailed data.) Many of the leading causes of death result from injuries, and most injuries are due to factors that are largely controllable in a child's immediate environment or by his or her actions.



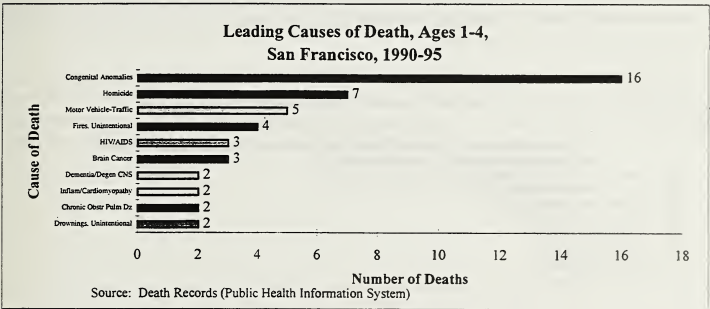
Homicide was the leading cause (175 deaths) of death for the entire 0 to 24 year old population, with 82% of homicides (143) occurring among youth ages 15 to 24. Congenital anomalies was the second leading cause of death and was most prominent among infants (70) and children ages 1 to 4 (16).

Congenital anomalies, homicide and HIV/AIDS were among the ten leading causes of death for all age groups. HIV/AIDS was most prominent (30 deaths) in the 15 to 24 age group.

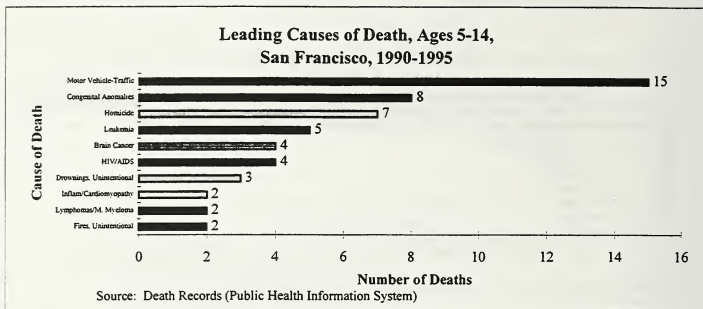
Age Less Than 1. From 1990 to 1995, Sudden Infant Death Syndrome (SIDS) was the leading cause of death for children less than one year of age, accounting for 85 deaths, or 23% of all deaths for this age group. The second and third leading causes of death were congenital anomalies (70 deaths) and birth asphyxia and trauma (43). The three leading causes of death combined accounted for over half (54%) all deaths for this age group.



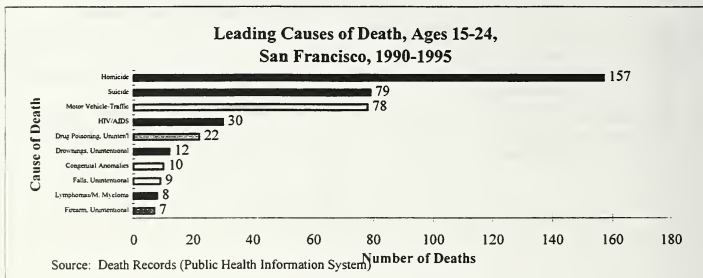
Ages 1 to 4. An average of 12 deaths per year occurred among children ages 1 to 4 during the six-year period, with congenital anomalies accounting for 22% (16) of all deaths in this age group.



Ages 5 to 14. Very few deaths (76) occurred in the 5 to 14 age group. Motor vehicle-traffic deaths were the leading cause of deaths among children ages 5 to 14, accounting for 20% (15) of deaths in this age group.



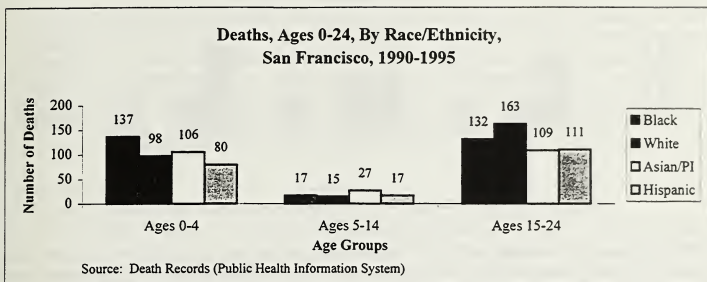
Ages 15 to 24. From 1990 to 1995, homicide was the leading cause of death (157) for San Francisco youth ages 15 to 24, an average of over 26 San Francisco youth murdered per year or about 30% of all deaths in this age group. Homicide among youth resulted in as many deaths as the next two leading causes combined, suicide (79) and motor vehicle traffic accidents (78). These three causes accounted for 60% of all deaths in this age group.



### Mortality by Race/Ethnicity

Among children and youth from birth to age 24, the greatest proportion (28%) of deaths were to Blacks (286 deaths), followed by Whites (26%; 276), Asian/Pacific Islanders (24%; 242), and Hispanics (20%; 208). Compared to the proportion of youth in San Francisco by race/ethnicity, Black youths are over represented among these dying, and Asian/Pacific Islander youth are under represented. Blacks

had the most deaths in the birth to age 4 group (137), Asian/Pacific Islanders in the age 5 to 14 group (27) and Whites in the age 15 to 24 group (163).

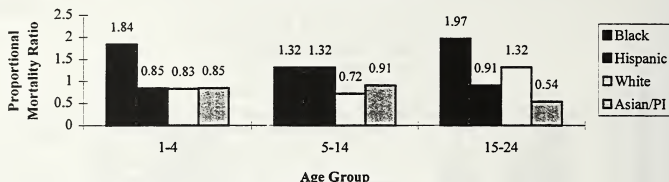


*Proportional Mortality.* The relatively small number of deaths among the children and youth population do not allow for reliable comparisons by the usual method of comparing rates, in occurrence of and event per 100,000 population. We can, however, compare the relative proportions of deaths by race/ethnicity to the proportion of the population in each age and race/ethnicity group. If all race/ethnicity groups had the same mortality rate, their proportional mortality would all be 1.0; in other words, groups with lower scores have a smaller share of the deaths in that age group than would be expected based on their share of the population, while groups with scores above 1.0 have more than their expected share of deaths.<sup>3</sup>

From 1990 to 1995, proportional mortality of Black children and youth for all age groups was disproportionately high compared to children and youth in other race/ethnic groups. This discrepancy was greatest among Black youth ages 15 to 24, who comprised 13% of San Francisco's 15 to 24 year olds, but represented 26% of the deaths in that age group.

<sup>3</sup> Note that proportional mortality is only useful for exploring the relative distribution of mortality across subgroups of a given population, regardless of whether the mortality of that whole population is high or low in comparison to any given standard. In that regard, San Francisco's overall rates for ages 1 to 14 are slightly below Healthy People 2000 objectives, while mortality for 15 to 24-year-olds is substantially above the objective. The age group rates can be taken as the "standard" in relation to which the age-specific proportional mortality is calculated. Thus the high proportional mortality for Black youth, and to a lesser extent White youth, are relative to an already high level of overall mortality for this age group.

### Proportional Mortality, By Age Group and Race/Ethnicity, San Francisco, 1990-95



Source: Death Records (Public Health Information System)

Black deaths were also disproportionately high within the 1 to 4 age group and were proportionally equal to Hispanic deaths in the 5 to 14 age group. Asians/Pacific Islanders had a lower share of deaths within all age groups. The proportion of deaths among Whites was slightly lower than expected in the 1 to 4 and 5 to 14 age groups, but higher than expected in the 15 to 24 age group.

## INJURIES

Injuries are a leading cause of death for children and youth in San Francisco and nationwide. The term “injury” represents a broad range of health outcomes, from those that do not require medical attention to those resulting in long-term disability or death. Injuries, like illnesses, occur in characteristic patterns in populations. The study of these patterns show how many injuries can be prevented. Multifaceted injury prevention strategies that are most effective focus on environmental design (such as road construction that improves visibility), product design, human behavior, education, and legislative and regulatory requirements that support environmental and behavioral change.<sup>4</sup>

### Data Sources

This section presents information about injuries from a variety of sources including:

- Death certificate data for 256 deaths due to injury of San Francisco children and youth residents, ages birth to 18, for a ten-year period, from 1986 to 1995. Note that these are deaths of individuals based on their place of residence, not the place of occurrence. (Refer to the Appendix for detailed data.)
- Hospital discharge data for 497 hospitalizations of San Francisco children and youth residents, ages birth to 18 treated for injuries at hospitals located in San Francisco in 1995. Note that the number of discharges does not necessarily reflect the number of patients since one patient may account for more than one discharge.<sup>5</sup> In addition, San Francisco children and youth residents who were hospitalized outside of San Francisco are not included in the data. (Refer to the Appendix for detailed data.)
- Data on calls to the California Poison Control System (CPCS) which originated in San Francisco in 1996/97, on behalf of victims ages birth to 19.
- Selected results from the 1997 San Francisco Youth Risk Behavior Survey (preliminary data) of San Francisco public middle and high school students with information regarding injury-related risk behaviors. Selected results of prior years’ surveys for San Francisco and the U.S. are also referenced.

### Cause and Intent of Injury

Injury deaths and hospitalizations can be categorized by cause (or mechanism) and “intent.” The cause or mechanism of injury identifies the agent, instrument, product, or activity, which was involved in the injury-causing incident. For example, the most common causes of injury death among San Francisco residents, children and youth ages birth to 18, are firearms, motor vehicle, suffocation, and drowning, and the most common causes of injury hospitalizations are falls, poisoning, motor vehicle collisions, and cutting/piercing injuries.

Injuries are also classified by “intent.” Intent categories include three major groups: unintentional (traditionally labeled as “accidents”), assault (the most severe being homicide), and self-inflicted (the

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<sup>4</sup> National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. *Health, United States, 1996-97 and Injury Chartbook*. MD: DHHS Publication No. (PHS) 97-1232, 1997; National Center for Injury Prevention and Control, *Injury in the U.S.*, obtained online August 7, 1998 at [www.cdc.gov/ncipc/about/about.htm](http://www.cdc.gov/ncipc/about/about.htm).

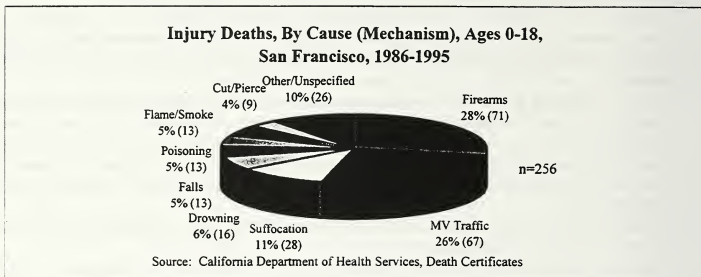
<sup>5</sup> Both death certificates and hospital discharge data use the External Cause of Injury (E code) of the World Health Organization’s International Classification of Disease Codes to categorize the circumstances of an injury-causing incident. E codes capture information about both the cause (mechanism) and intent of the injury.

most severe being suicide). Caution must be used in interpreting the assigned intent of an injury. The assignment of “intent” is often made on the basis of incomplete evidence because those involved in an injury event may not be alive, present, and/or willing to answer questions about the circumstances causing the injury.<sup>6</sup>

### Leading Causes of Injury Deaths

During the ten-year period from 1986 to 1995, a total of 256 San Francisco children and youth died as a result of injuries. During the five-year period from 1990 to 1995, injury deaths accounted for almost half (45%; 458) of all deaths among children and youth ages birth to 24.<sup>7</sup>

By order of magnitude, the top three leading causes (mechanisms) of injury deaths were firearms (28% of all injury deaths), motor vehicle traffic (26%), and suffocation (11%).



From 1986 to 1995, 75% (192) of injury deaths were among males and 64 injury deaths were among females.

African Americans represented 30% of injury deaths (77) – a disproportionate share compared to the percent in the population.<sup>8</sup> The percent of injury deaths for other race/ethnicities was 26% Asian (67), 20% White (52), 19% Hispanic (50), and 4% other (10). The leading cause of injury deaths among African American and Hispanic children and youth was firearms, with 36% of injury deaths among African Americans (28) and 30% of injury deaths among Hispanics (15) due to firearms. The leading cause of death among Asian and White children and youth was motor vehicle traffic/non-traffic, with 39% of injury deaths among Asians and 34% of injury deaths among whites. Identifying injury deaths of San Francisco children and youth residents by racial/ethnic categories for other causes is difficult due to relatively small numbers for each cause. (Refer to the Appendix for detailed data.)

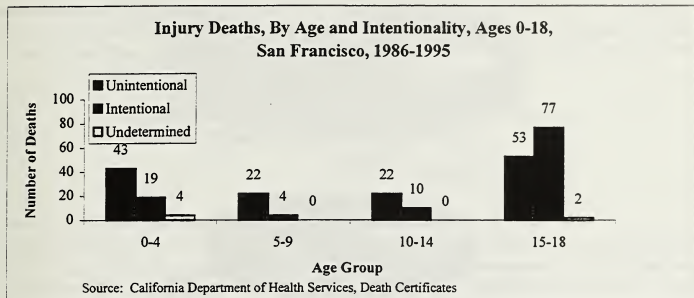
<sup>6</sup> San Francisco Injury Center, San Francisco Department of Public Health. Profile of Injury in San Francisco, 1996.

<sup>7</sup> The total number of deaths in this age group during this six-year period was 1,027. These 458 injury deaths represent 13% of all injury deaths (3,445) for all ages in San Francisco for the same time period. Data on the proportion of injury deaths compared to all deaths for ages birth to 18 for the ten-year period from 1986 to 1995 was not available.

<sup>8</sup> According to the California Department of Finance, in 1996, African Americans comprised approximately 16% of the age 0 to 14 population and 22.5% of the age 0 to 24 population. Refer to the “Demographics” section of this report for data on population by race/ethnicity.

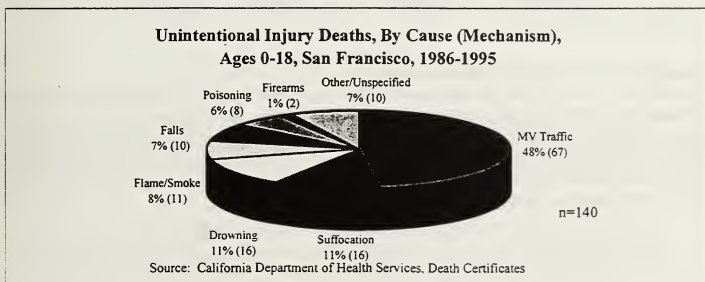
### Intent of Injuries That Resulted in Death

During the ten-year period from 1986 to 1995, slightly over half (55%) of injury deaths (140) for children and youth were unintentional, 43% (110) were intentional, and 2% (6) were of undetermined



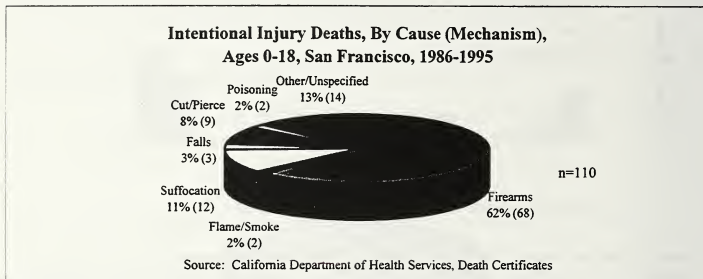
intent. Infants and young children ages birth to 14 were more likely to be killed as a result of unintentional injuries while youth ages 15 to 18 were more likely to be killed due to intentional injuries.

Unintentional. From 1986 to 1995, motor vehicular traffic was the leading cause (mechanism) of unintentional injury deaths, accounting for nearly half (48%) of unintentional injury deaths (67), including half (51%) among youth ages 15 to 18 (34). Suffocation and drowning were the next most common causes of unintentional injury deaths, each accounting for 11% of unintentional injury deaths (16). Most suffocation deaths (81%) were among young children ages birth to 4 (13).



Flame/smoke was the fourth leading cause of unintentional injury deaths, comprising 8% (11) of unintentional injury deaths. Nationally, most flame injury/deaths are due to house fires and most fatal house fires are caused by cigarettes.<sup>9</sup>

**Intentional.** From 1986 to 1995, three-fourths (75%; 83 deaths) of intentional injury deaths among children and youth were classified as homicides (assault) and 25% (27) were classified as suicides (self-inflicted). The majority (70%) of intentional injury deaths were among youth ages 15 to 18.



Firearms were the leading cause of intentional injury deaths and were responsible for about two-thirds (62%; 68 deaths) of intentional injury deaths. Most (91%; 62) intentional injury deaths caused by firearms were among males and a majority were among youth ages 15 to 18 (57 deaths). Most intentional firearm deaths were homicides (84%; 57), mostly among youth ages 15 to 18 (46 deaths). All suicide deaths caused by firearms (11) were among youth ages 15 to 18.

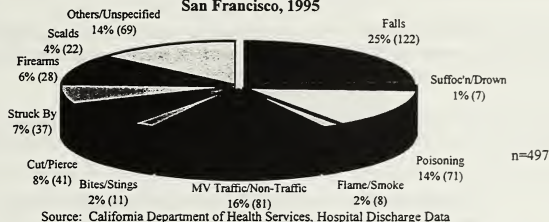
Suffocation was the second leading cause of intentional injury deaths, accounting for 11% (12 deaths) of intentional injury deaths. Most intentional suffocation deaths were suicides (8 deaths) among adolescents ages 15 to 18.

### **Leading Causes of Injury Hospitalizations**

In 1995, there were 497 hospitalizations of children and youth ages birth to 18 because of injury, an average of 10 injury-related hospitalizations per week. Injuries which result in hospitalization are relatively serious and may result in disability or long-term consequences. Most injury hospitalizations (64%; 320) were among males. By order of magnitude, the top three leading causes (mechanisms) of injury hospitalizations in 1995 were falls (25% of injury hospitalizations), motor vehicle traffic/non-traffic (16%), and poisoning (14%).

<sup>9</sup> Baker, Susan P., et. al., The Injury Fact Book, 2<sup>nd</sup> Edition, New York: Oxford University Press, 1998

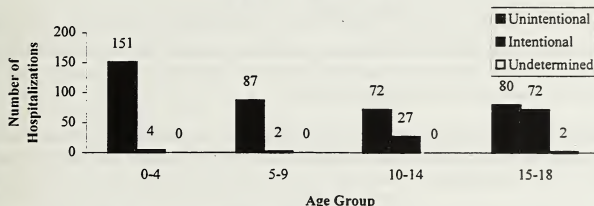
### Injury Hospitalizations, By Cause (Mechanism), Ages 0-18, San Francisco, 1995



### Intent of Injuries That Resulted in Hospitalizations

In 1995, most injuries resulting in hospitalizations (79%; 390) were considered unintentional, 21% (105) were intentional, and <1% (2) were of undetermined intent. Infants and young children were much more likely to be hospitalized due to unintentional injuries compared to youth ages 15 to 18, who

### Injury Hospitalizations, By Age and Intentionality, Ages 0-18, San Francisco, 1995



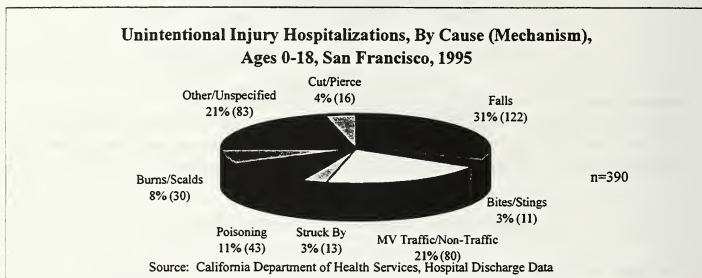
were almost equally likely to be hospitalized due to unintentional and intentional injuries. Hospitalizations for unintentional injuries accounted for 90% of injury hospitalizations among children 14 years and younger compared to slightly more than half (52%) of injury hospitalizations among youth ages 15 to 18.

**Unintentional.** Falls were the leading cause (31%) of unintentional injuries which resulted in hospitalizations (22) among children and youth ages birth to 18. Over two-thirds (69%) of all hospitalizations for falls involved children ages birth to 9. It should be noted that in very young

children, serious injuries reported as falls are often found to be the result of abuse but are classified as “unintentional” until abuse can be verified.<sup>10</sup>

Motor vehicle traffic/non-traffic was the second leading cause of unintentional injuries resulting in hospitalizations, accounting for 21% (80) of unintentional injury hospitalizations, mainly in the age 15 to 18 group (25 hospitalizations).

Poisoning was the third leading cause of unintentional injuries resulting in hospitalizations (43 hospitalizations) with about half (21) occurring in the birth to 4 age group. Note that the category



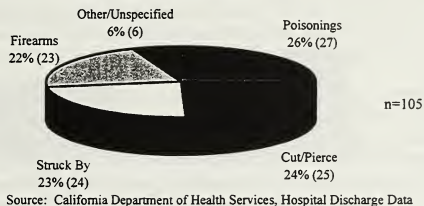
“poisoning” includes many different toxic syndromes, both unintentional (such as ingestion by young children of toxic substances, and occupational and environmental exposures and substance abuse poisonings) and intentional (such as suicide attempts).

Burns and scalds were especially a problem among infants and young children ages birth to 4, with 19 of 22 hospitalizations for burns and scalds among children from birth to age 18 occurring within this age group.

Intentional. Three-fourths (75%) of hospitalizations for intentional injury (78) were classified as assault and one-fourth (25%) were classified as self-inflicted (27). Firearms accounted for 22% (23) of

<sup>10</sup> Wilson Modena Hoover, et al., Saving Children – A Guide to Injury Prevention, New York: Oxford University Press, 1991

### Intentional Injury Hospitalizations, By Cause (Mechanism), Ages 0-18, San Francisco, 1995



hospitalizations for intentional injury with most occurring in the 15 to 18 age group (19) and the remainder in the 10 to 14 age group (4). The higher proportion of firearms as the cause of deaths compared to hospitalizations (62% vs. 22%) clearly illustrates the lethality associated with firearm use.

Other mechanisms for assaults were “cut/pierce” (25 hospitalizations) which involves being cut and pierced by instruments or objects and “struck by” (24) which involves being hit by a blunt object or person.

All hospitalizations for injuries among children and youth in 1995 classified as self-inflicted resulted from poisonings. These hospitalizations occurred among children ages 10 to 14 (12 hospitalizations) and youth ages 15 to 18 (15). Most “cut/pierce” and “struck by” intentional injury hospitalizations (37) were among adolescents ages 15 to 18.

### Poison Control Center Calls

Data from the California Poison Control System (CPCS) provides additional information about the frequency and type of injuries occurring among children and youth in San Francisco. The CPCS provides immediate treatment advice and poison information to both the public and to health professionals in San Francisco and other California counties.

In 1996/97, the CPCS received a total of 2,661 calls from San Francisco County on behalf of victims 19 years old or younger, or 35% of all calls received from the county.<sup>11</sup> Three-fourths (74%) of these calls were for children ages birth to 5, mostly for children 2 years old or younger.

A majority (87%; 2,320) of calls were for incidents in which exposure was unintentional including “general” – usually referring to a curious toddler who ingested a toxic substance while exploring his or her environment. “Other” unintentional exposures include therapeutic error, environmental, food poisoning, and bites/stings. One of ten (10%) calls were for intentional exposures including suspected suicide and abuse/misuse, and 3% of calls were for adverse drug or food reactions, or other reasons.

<sup>11</sup> The 1996/97 period is from September 1996 through August 1996. Calls from San Francisco were from callers who were may or may not be residents of the county. Alternatively, San Francisco residents calling from other counties are not included among these calls. 37 calls from South San Francisco were also included among the 2,661 calls.

Nearly all (98%; 2,596) incidents occurred at the child's residence. Other sites of exposure included schools, other residences, public areas, and other locations.

The majority of calls to the CPCS resulted in management of the incident on site, without further medical intervention. In 1996, there were no known deaths due to exposures. Less than 1% (17) resulted in a "major effect" for the victim.

Data on the location of callers by zip code was not available for the 1996/97 period. However, an analysis of 1993 data comparing the geographic distribution by zip code of residents who phoned the CPCS regarding a poisoning exposure versus residents who were hospitalized for poisoning/drug overdose showed a difference in the characteristics of the two populations. Poisoning/drug overdose hospitalizations were associated with men ages 25 to 44 from low per capita income areas of the City such as the downtown and South of Market areas. Calls to the CPCS were distributed equally along gender lines, with a disproportionate number of calls regarding children. Calls were not concentrated in areas of the City with low per capita income. Those who had called had access to a phone and knowledge of whom to call.<sup>12</sup>

### **Injury Risk Behaviors**

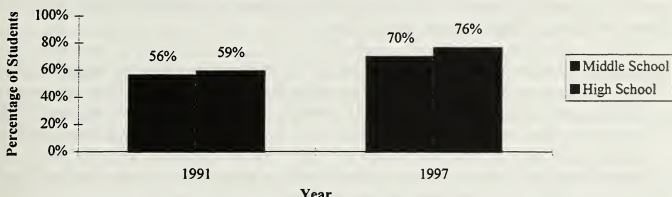
This section provides data on the prevalence of specific risk behaviors, as reported by San Francisco public school students at the middle and high school levels. These risk behaviors are associated with the occurrence of unintentional and intentional injuries. An important focus of injury prevention is modifying these behaviors as well as creating environments which promote healthy behaviors.

Risk Behaviors for Unintentional Injuries. Both seat belt and helmet use has been rising among all students since 1991. In 1997, 70% of middle school students reported that they wore a seat belt "always" or "most of the time" compared to 56% in 1991. Only 13% of middle school students reported that they "rarely" or "never" wore a seat belt when riding in a car. The proportion of high school students who reported that they used seat belts "most of the time" or "always" when riding in a car driven by someone else increased from 59% in 1991 to 76% in 1997. Nationwide, 22% of students reported that they "rarely" or "never" used safety belts when riding in a vehicle driving by someone else, or almost three times worse than San Francisco students (8%).

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<sup>12</sup> San Francisco Injury Center, San Francisco Department of Public Health. Profile of Injury in San Francisco, 1996.

**Reported Use of Seat Belts "Always" or "Most of the Time",  
Public Middle and High School Students, San Francisco, 1991 and 1997**



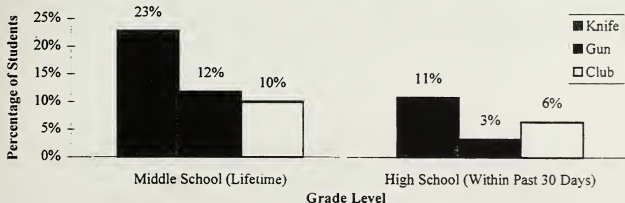
Source: San Francisco Unified School District, San Francisco Middle and High School Youth Risk Behavior Survey, 1991 and 1997

Most middle school students reported that they rode a bicycle or rollerbladed (74%) or rode a skateboard (60%) in the past. More than half who bicycled (51%) or rollerbladed or skateboarded (64%) reported that they "never" or "rarely" wore a helmet. However, the proportion of middle school students who reported using a helmet "most of the time" or "always" when bicycling increased significantly since 1991 (from 6% in 1991 to 24% in 1995).

About one-fourth (26%) of middle school students and one-fifth (21%) of high school students reported that, within the past 30 days, they rode in a vehicle with someone who had been drinking alcohol. In addition, 5% of high school students reported they had, within the past 30 days, driven a car after they had been drinking.

**Risk Behaviors for Intentional Injuries.** Nearly one-fourth (23%) of middle school students reported ever carrying a knife, 10% had carried a club, and 12% had carried a gun as a weapon. This compares

**Weapon Carrying, Public Middle and High School Students,  
By Type of Weapon, San Francisco, 1997**



Source: San Francisco Unified School District, San Francisco Middle and High School Youth Risk Behavior Survey, 1991 and 1997

to 14% of the high school students who reported that they had carried a weapon within the past 30 days, including 11% who had carried a knife, 6% who had carried a club and 3% who had carried a gun.

In addition, more than one in ten middle school students (12%) reported that they had ever carried a knife or club and 3% carried a gun on school property. Eight percent of high school students reported that they had carried a weapon, knife or club on school property or within the past 30 days. Males were more likely to carry weapons than females.

Other results from the YRBS pertaining to risk behaviors for intentional injury include the following:

- *Feeling Unsafe At School:* Sixteen percent of middle school students said they did not go to school at least once because they felt they would be unsafe at school. Seven percent of high school students reported not going to school within the past 30 days because they felt they would be unsafe at school, and on the way to or from school. Nearly one in ten (9%) high school students reported that they had been threatened or injured by someone with a weapon, such as a gun, knife, or club on school property within the past 30 days.
- *Physical Fights:* More than half (53%) of middle school students reported that they had been in a physical fight in the past year and mostly with someone they knew but didn't like. Over one-quarter (27%) of high school students reported that they had been in a physical fight in the past year. Significantly more students in the national survey reported that they engaged in a physical fight (39% vs. 28%).
- *Violence-Related Incidents:* The proportion of high school students reporting violence-related incidents in general decreased slightly during the past four years, including weapon-carrying (from 21% in 1991 to 19% in 1995) and physical fighting (from 35% in 1991 to 28% in 1995).

## CHILDHOOD LEAD POISONING

Lead is a toxic substance and lead poisoning in children under six years of age is associated with reduced learning ability and poor school performance in later years, and other problems with growth and development. Young children, especially one- and two-year olds, are at highest risk for lead exposure because of their hand-to-mouth behavior and their close proximity to lead contaminated surfaces (e.g., floors, windowsills) which leads to ingestion of lead-based paint dust and chips. Young children are also the most susceptible because their rapidly developing nervous systems are vulnerable to the effects of lead exposure.

High blood lead levels are considered one of the five top environmental threats to the health of children in the U.S.<sup>1</sup> Childhood lead poisoning is entirely preventable. In the U.S., reduced levels of lead in gasoline, air, food, and industrial sources have reduced exposure to lead. Currently, lead in the home environment is considered the foremost cause of lead exposure, especially in inner-city urban areas in which lead has been reduced only to a limited extent.

### Risk in San Francisco

The risk of lead poisoning is considered high in San Francisco because of the large concentration of housing built before 1950 which is assumed to contain lead-based paint and lead-contaminated dust and soil. San Francisco ranks first among California counties in the percentage of homes built before 1950 (68% of all housing units). In addition, 94% of the City's housing stock was built before 1978 when lead was banned from use in residential paint. Many properties in the City have contaminated soil due to deteriorating exterior paint surfaces or from construction and renovation. Lead exposure from ceramic ware and lead-containing home remedies are also relevant factors in San Francisco.

### Data Source

Since 1991, the San Francisco Department of Public Health's Childhood Lead Prevention Program (CLPP) has collected data on blood lead tests performed by various health care providers in the City.<sup>2</sup> Currently, no universal reporting system is in place to capture data on blood lead levels of children in San Francisco.<sup>3</sup> Therefore, all data reported to the CLPP is provided on a voluntary basis.<sup>4</sup> In addition, CLPP data disproportionately represents low income children as opposed to children from middle and upper income levels with private insurance coverage. Based on these limitations, the results of CLPP surveillance data cannot be generalized beyond the CLPP sample population.

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<sup>1</sup>Natural Resource Defense Council, *Are Our Children at Risk?*, 1997

<sup>2</sup>The two main sources of data are healthcare providers and labs. A large number of tests are received from San Francisco Department of Public Health Centers (Castro-Mission; Silver Avenue Family; Chinatown Public), San Francisco General Hospital, Mission Neighborhood Health Center, North East Medical Services, St. Mary's Hospital, St. Luke's Hospital, and Mt. Zion Hospital.

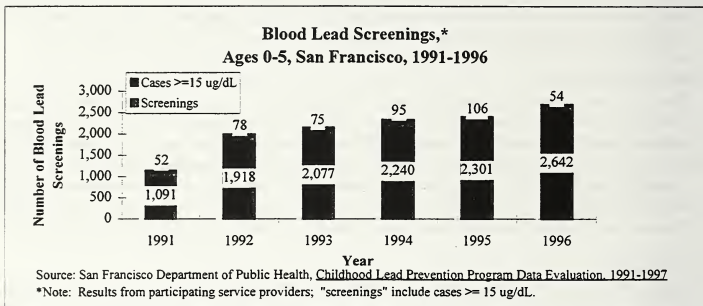
<sup>3</sup>In 1992, California established a legal requirement that publicly-funded health care providers test all children under 6 years old for lead poisoning; the number of children tested increased substantially following this legislation. The federal Center for Disease Control guidelines recommend that all children one and two years of age receive blood lead testing.

<sup>4</sup>"Universal reporting" refers to reporting of all blood lead levels for children under the age of six years.

CLPP has collected data on 12,269 children in San Francisco under the age of six who received initial blood lead testing between 1991 and 1996. CLPP estimates that these children represent at most only 5 to 15% of San Francisco children eligible for blood lead screening.<sup>17</sup>

### Blood Lead Screening Results

From 1991 to 1996, blood lead screening per year has more than doubled with increases observed every year. During this period, 8.4% of children screened had initial blood lead levels that were elevated at or above the federal Centers for Disease Control level of concern,  $\geq 10$  ug/dl. A total of 460 children (3.7%) were classified as "cases" with an initial blood lead level of greater than or equal to 15 ug/dl. The number of cases (greater than or equal to 15 ug/dL) peaked in 1995 at 106 children or 4.6% of screens, and dropped by half to 54 children or only 2.0% of screens in 1996. This decline follows national trends and suggests that extensive education and outreach efforts have had a positive impact on reducing lead exposure.



In addition, other factors maybe contributing to the decline in San Francisco in case findings including: 1) detection of only new (incident) cases rather than both new and previously existing (prevalent) cases, and 2) a drop in the number of children screened from high risk groups (specifically, Caucasian and African-American children).<sup>18</sup>

Based on these test results and the number of children eligible for blood lead screening but for whom test results have not been provided, CLPP estimated that in 1997 there were 897 children in San Francisco with undiagnosed elevated lead levels (greater than or equal to 15 ug/dL).<sup>19</sup>

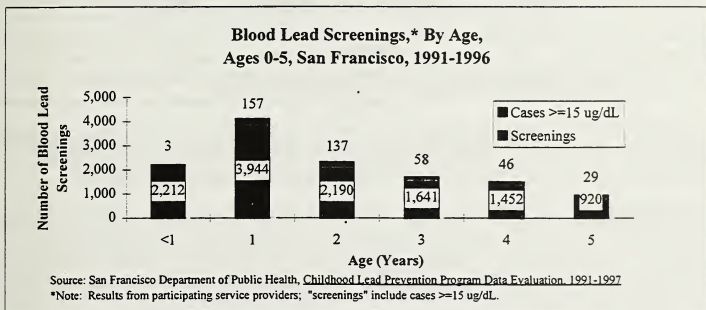
<sup>17</sup> An estimate by CLPP based on the number of annual births in San Francisco and estimates of the number of one and two-year olds eligible for lead testing.

<sup>18</sup> Healthy People 2000 objective regarding elevated blood lead levels refers to nation-wide prevalence goals. Objective 11.4 is to reduce the prevalence of blood lead levels greater than or equal to 15  $\mu$ g/dL and 25  $\mu$ g/dL among children aged 6 months through 5 years to no more than 500,000 and zero. Objective 11.4a is to reduce the prevalence of blood lead levels exceeding 15  $\mu$ g/dL and 25  $\mu$ g/dL among inner-city low-income black children aged 6 months through 5 years to no more than 75,000 and zero, respectively.

<sup>19</sup> San Francisco Department of Public Health, Childhood Lead Prevention Program Data Evaluation, 1991-1997.

The prevalence rate in San Francisco of blood lead levels greater than or equal to 10 ug/dL (the federal Centers for Disease Control's level of concerns) for the same time period was 8.4% (5% at 10 to 14 ug/dL; 2% at 15 to 19 ug/dL; 1% at 20+ ug/dL, close to the national estimate of 8%.<sup>20</sup>

By Age. A third (32%) of the screenings were for one-year olds (3,944), followed by two-year olds (2,190), and children under one year of age (2,122).<sup>21</sup> The highest proportion of elevated blood lead levels were found among two-year olds with 6.3% who had elevated lead levels (greater than or equal to 15 ug/dL), followed by 4.0% of one-year olds. These results indicate one- and two-year olds as the highest risk groups in San Francisco.

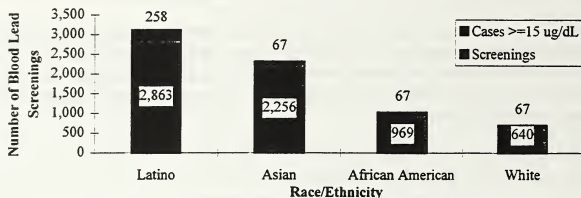


By Race/Ethnicity. Race/ethnicity information was available for about half of the children screened. The race/ethnicity of children screened reflects outreach efforts by CLPP to target specific communities considered at high-risk for lead poisoning. Among children whose race/ethnicity was known, Latinos comprised 42% of screens, followed by Asian (34%), African-American (14%), and white (10%). Latino children accounted for 55% (258) of children found with elevated lead levels, while additional elevated levels were evenly divided among African Americans (15%; 67 children), White (15%; 67), and Asians (15%; 67). Compared to other race/ethnic groups, White and African

<sup>20</sup> U.S. Department of Health and Human Services, Centers for Disease Control, Preventing Lead Poisoning in Young Children, October 1991.

<sup>21</sup> Thirty children 6 years of age who were screened were not included in these percentages.

**Blood Lead Screenings,\* By Race/Ethnicity,  
Ages 0-5, San Francisco, 1991-1996**



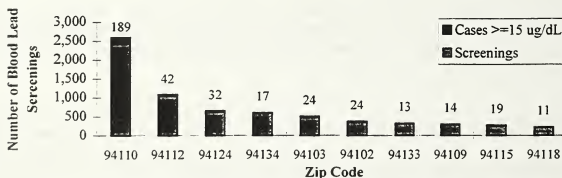
Source: San Francisco Department of Public Health, Childhood Lead Prevention Program Data Evaluation, 1991-1997

\*Note: Results from participating service providers; "screenings" include cases  $\geq 15$  ug/dL.

American children appear to be most at risk, based on the proportion of screens with elevated blood lead levels, up to 26.5% for White and up to 17.3% for African Americans in 1995, although the number of children tested among both groups have significantly dropped in recent years.

By Neighborhood. Zip code information was available for 60% of the children screened. Children in 10 zip codes comprise 89% of children screened with known zip codes. The highest numbers of children were screened (2,421) and with elevated blood lead levels (7.8% of screens) were found in the Mission District (94110 zip code), where older housing is plentiful. Mission Neighborhood Health Clinic and San Francisco General Hospital, both situated in the Mission District, account for over half (53%) of the total screening tests reported. Two additional neighborhoods, Western Addition (94115) and Hayes Valley/portion of Tenderloin (94102) had high proportions of elevated levels (7.5% and 6.8%, respectively) although the numbers of children screened were small. CLPP concludes that the uneven distribution of screening tests make it difficult to draw conclusions about the geographic zones at risk in San Francisco.

**Blood Lead Screenings,\* In "Top 10" Zip Codes,  
Ages 0-5, San Francisco, 1991-1996**



Source: San Francisco Department of Public Health, Childhood Lead Prevention Program Data Evaluation, 1991-1997

\*Note: Results from participating service providers; "screenings" include cases  $\geq 15$  ug/dL.

## IMMUNIZATION AND INFECTIOUS DISEASES

The reduction in the occurrence of infectious diseases is the most significant public health achievement of the past 100 years. An improved standard of living, improved hygiene, regulations for food handling, water treatment, the availability of antibiotics and the widespread use of vaccines have all led to prevention and control of infectious diseases. Nonetheless, infectious diseases remain important causes of illness and death in the U.S.<sup>1</sup>

### Importance of Immunization<sup>2</sup>

Immunization is the most effective and inexpensive tool for prevention of communicable diseases. The introduction of vaccines has resulted in dramatic reductions in the numbers of reported cases of vaccine preventable diseases. Immunization saves from \$1.70 to \$14.60 for every \$1 spent depending on the particular vaccine.<sup>3</sup> Vaccines made possible the worldwide elimination of smallpox in 1977 and the elimination of polio from the Western Hemisphere in 1991.

Childhood Vaccines. Vaccine preventable diseases are those diseases for which there are effective vaccines and well-established recommendations for routine childhood immunization. These diseases are tracked as the ultimate measure of immunization success. To reach the goal of elimination of vaccine preventable diseases, we must achieve a critical mass of immunized individuals. As we approach successful immunization coverage, there are fewer cases of vaccine-preventable diseases, they are less likely to spread, and counting cases becomes a less effective tool to measure coverage. As we achieve high immunization levels in our children the diseases become less visible, there is less perceived threat from them and less appreciation of the importance of complete immunization. For example, both polio and measles are uncommon in the U.S., yet the threat remains that both diseases will be re-introduced into the U.S. from another country where immunization is less successful.

Not all the diseases for which we immunize infants and children pose a major threat for young children. For example, Rubella (German measles) is a mild illness with few complications for adults and children alike. However, infection during pregnancy can result in serious effects on the fetus. Another example is Hepatitis B which is primarily a sexually transmitted disease; most infants and children are not at risk.

Adolescent Vaccines. Adolescents also need immunization. Tetanus/diphtheria immunization should be repeated every ten years. Because measles outbreaks are a problem in colleges and universities, many institutions require a second dose of MMR (measles, mumps, rubella) at entry. Adolescents who are sexually active or use injection drugs are at risk for developing hepatitis B. While future generations of adolescents will have been immunized against Hepatitis B as infants, the current generation of adolescents have not been immunized.

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<sup>1</sup> U.S. Department of Health and Human Services, Healthv People 2000: National Health Promotion and Disease Prevention Objectives; U.S. Department of Health and Human Services, Healthv People 2000 Midcourse Review and 1995 Revisions

<sup>2</sup> San Francisco Department of Public Health, Immunization in San Francisco, presentation to the San Francisco Health Commission

<sup>3</sup> California Department of Health Services, Immunization Branch, January 1993

## Standards For Immunization

Currently, the recommended basic immunization schedule specifies that children by the age of 24 months receive four doses of the diphtheria-tetanus-pertussis (DTP) vaccine, three doses of the polio vaccine, and a single dose of the measles-mumps-rubella (MMR) vaccine. Thus, while additional doses are recommended at school entry and throughout life, 2 years (24 months) is a common age at which to assess immunization completion. Immunizations should be given at the recommended ages because protection may be very age-specific. For example, Hib (*Haemophilus influenzae* type b) and pertussis immunization provides little protection to school-age children because it is younger children who are at risk of Hib or pertussis complications.

In California, children entering kindergarten have additional immunization requirements including three HBV (hepatitis B) vaccine. The vaccine for Hib (*Haemophilus influenzae* type b), the most common cause of bacterial meningitis in U.S. children, is included in the infant immunization schedule. School entry requirements have been very successful at ensuring appropriate immunization for children at five years of age. (Refer to the Appendix for immunization requirements for California and recommended immunization requirements for the U.S.) California has seen at least 95% completion rate for vaccinations by school age for at least ten years, although we have been much less successful in achieving completion of recommended doses by 2 years of age.

## Measuring Childhood Immunization Coverage

Currently, there is no single, ongoing, comprehensive centralized repository of data on the immunization status the City's children. However, there are various ways to estimate the population immunization rate such as sampling of medical records, random door-to-door surveys, or random telephone surveys. There are issues of cost, accuracy, timeliness and other considerations to each of these approaches.<sup>4</sup>

## Kindergarten Retrospective Survey

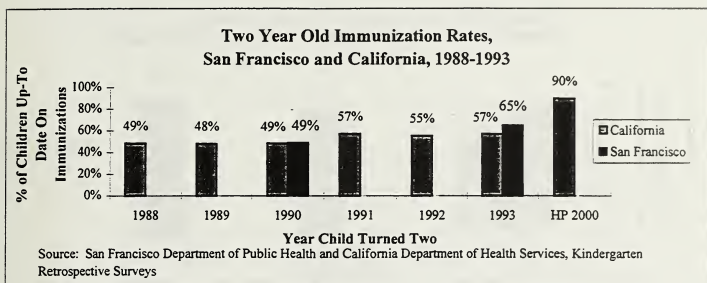
The San Francisco Department of Public Health conducts periodic surveys to assess the immunization status of two-year-olds in the City, using the kindergarten retrospective survey method. The most recent survey was conducted in 1996, which provided an estimate of the immunization status of two year olds in 1993. The kindergarten retrospective method utilizes immunization records collected by the schools in conjunction with the requirements for school entry. It is relatively easy and inexpensive to survey these school records and then calculate how well immunized these children were three years previously, when they were age two. The main disadvantages of this method are that the estimate of immunization rates are at least two years old, and school-based records may be less accurate than medical records.

The 1996 survey showed an overall completion rate of 65% for San Francisco two-year-olds (as of 1993), which is an improvement over the rate of 49% for San Francisco children in 1990. It also compares well with the statewide rate of 57%. (The San Francisco and state surveys used the same

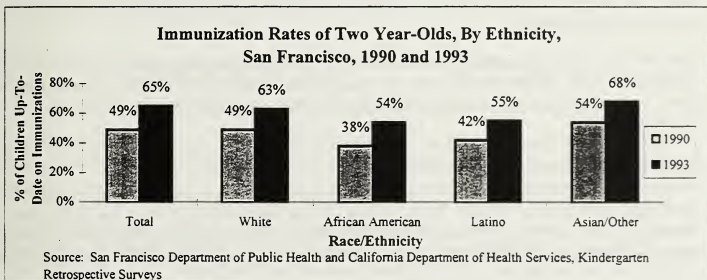
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<sup>4</sup> For example, random door-to-door and telephone methods are expensive, and many calls or visits must be made before successfully identifying an appropriate household. Also, every family does not have a telephone, and children who are not immunized may live in households without telephones, a major bias to telephone-based surveys. Language diversity is also a major challenge in San Francisco. Information collected from immunization records at home may not be accurate. Other tools available to measure progress on toddler immunization coverage include surveillance of disease, an outcome measurement but a very "late-warning" system; and provider surveys which are limited to those in care and complicated by changes of provider and by multiple providers for each patient.

methodology, so the results are considered comparable.) However, San Francisco has not reached the national Healthy People 2000 goal of 90% of children adequately immunized by age two.<sup>5</sup>



Immunization coverage in San Francisco improved for all racial groups between 1990 and 1993, although relative standings remain. Asians had the best results with 68% up-to-date at 24 months. This can be broken down into 72% for Chinese, 82% for Southeast Asians and 56% for Filipinos. African-Americans, Latinos, and Whites had 54%, 55%, and 63% rates of completion, respectively.

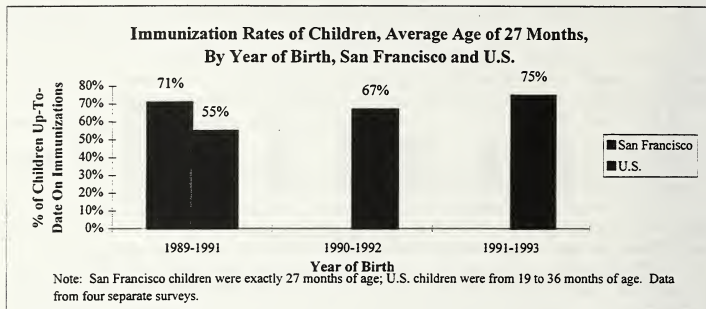


National data on immunization rates is not directly comparable to San Francisco and California immunization surveys.<sup>6</sup> However, when U.S. data is adjusted for age of the children based on year of

<sup>5</sup> In addition to this objective, Healthy People 2000 objective 20.1 is to completely eliminate indigenous cases of vaccine-preventable diseases in the U.S. for diphtheria among people aged 25 and younger, tetanus among people ages 25 and younger, polio, measles, rubella, congenital rubella syndrome; reduce mumps to 500 cases, and reduce pertussis to 1,000 cases.

<sup>6</sup> National immunization rates are calculated from random telephone surveys and include children 19 to 35 months old, with an average age of 27 months. The differences in age of the children, source of the information (school records used for the retrospective survey versus immunization cards used for the telephone survey), and the requirement of a telephone in the household make telephone surveys not directly comparable to kindergarten retrospective surveys. Since the

birth, San Francisco compares favorably with national surveys for the 1989 to 1991 period. Nevertheless, rates remain well below the national Healthy People goal of 90% for all races/ethnicities.



In the 1993 San Francisco survey, boys were more likely to be immunized than girls in all races/ethnicities except Latino, 62% boys vs. 60% girls for whites, 54% vs. 52% for African Americans, 58% vs. 49% for Filipinos, and 78% vs. 65% for Chinese. The difference was statistically significant only for Chinese children. For Latino children a higher percentage of girls (56%) than boys (53%) were up-to-date.

The 1993 San Francisco survey found that nearly 11% of the children immunized were given at least one dose too early. Either the child was too young for the vaccine to be effective or the vaccine was given too soon after the previous dose to be effective. This compares with 16% of children in a national survey.

#### **Incidence of Vaccine Preventable Diseases**

Identifying the occurrence of vaccine preventable diseases provides a “late warning” system for monitoring a community’s health. From 1990 to 1997, children and youth up to age 18 represented a large proportion of several vaccine preventable diseases in the City including diphtheria (100% of all cases), whooping cough (86%), mumps (46%), measles (42%), and rubella (38%). During the same

**Reported Cases of Vaccine Preventable Diseases,  
By Age Groups,  
San Francisco, 1990-1997**

<u>Disease</u>	Age Groups				
	0-18		19-24		All
	# of Cases	% of All Cases	# of Cases	% of All Cases	# of Cases
Diphtheria	1	100%	0	0%	1
Hepatitis A	230	7%	408	13%	3,176
Hepatitis B	40	6%	125	20%	621
Hib	14	10%	4	3%	134
Measles	22	42%	6	12%	52
Mumps	13	46%	3	11%	28
Polio	0	-	0	-	0
Rubella	3	38%	0	0%	8
Tetanus	0	0%	0	0%	1
Whooping Cough	63	86%	1	1%	73

Source: San Francisco Department of Public Health, Community Health Epidemiology Section, 1998

eight year period, youth ages 19 to 24 represented 20% of the City's Hepatitis B cases, 13% of Hepatitis A cases, and 11% of mumps and measles cases. (Refer to the Appendix for more detailed data.)

The Healthy People 2000 goal is to completely eliminate the occurrence of diphtheria and tetanus among people ages 25 and younger, and to completely eliminate polio, measles, and rubella among individuals of all ages. As of 1997, San Francisco has achieved the Healthy People 2000 objectives for diphtheria and tetanus (ages 25 and younger) and polio, but not for measles and rubella.

Like several other counties in California, San Francisco is in the midst of a Hepatitis A outbreak in adults and adolescents. Although all of the factors contributing to the epidemic are not known, Hepatitis A is more common among gay/bisexual men and injecting drug users. Youth are an important group to immunize because they are likely to be first exposed to Hepatitis A as adolescents or young adults. From 1990 to 1997, 7% (230 cases) of San Francisco Hepatitis A cases occurred among 0 to 18 year olds and another 13% among youth ages 19 to 24 (408 cases).<sup>7</sup>

<sup>7</sup> There are no Healthy People 2000 objectives for Hepatitis A, B, and C specifically addressing youth. Healthy People 2000 objective 20.3 is to reduce Hepatitis A to 16 per 100,000 (for all ages) and Hepatitis B to 40 per 100,000 (for all ages). Subobjectives 10.3a through 20.3k provide Hepatitis A, B, and C goals for a variety of other target populations.

### **Incidence of Other Communicable Diseases**

By requiring the reporting of communicable diseases, local health authorities can monitor the occurrence of outbreaks and work to prevent their further spread. Among the reportable diseases in San Francisco that are not preventable through vaccines, the most commonly occurring are *Campylobacter*, *Giardia*, *Salmonella*, and *Shigella*.

The bacterial species *Campylobacter*, nontyphi *Salmonella*, and *Shigella*, and the parasite *Giardia Lamblia* are the most common causes of nonviral human enteric (intestinal) infections in the United States and are responsible for significant morbidity and financial costs. *Salmonella* and *Campylobacter* infections are acquired from ingestion of undercooked food products (e.g., poultry, eggs) where animals are reservoirs of the bacteria. *Giardia* infections result primarily from person-to-person transmission through fecal-oral routes, although contaminated water has caused outbreaks. Humans are the only reservoir for *Shigella* and transmission occurs person-to-person through fecal-oral routes. *Salmonella* and *Giardia* are among the communicable diseases that can result in a chronic infection or carrier state.

From 1990 to 1997, most notable among cases of communicable diseases were the large number of cases among children ages 0 to 18 of *Campylobacter* (1,427) and the large proportion (38%) of all cases of *Salmonella* (614) which occur in children ages 0 to 18. Children ages 0 to 18 comprised 23%

**Reported Cases of Selected Communicable Diseases,  
By Age Groups,  
San Francisco, 1990-1997**

<u>Disease</u>	Age Groups				
	0-18		19-24		All
	# of Cases	% of Cases	# of Cases	% of Cases	# of Cases
<i>Campylobacter</i>	1,424	27%	452	9%	5,259
<i>Giardia</i>	655	23%	191	7%	2,870
<i>Salmonella</i>	614	38%	116	7%	1,619
<i>Shigella</i>	627	28%	116	5%	2,252

Source: San Francisco Department of Public Health, Community Health Epidemiology Section, 1998

of all *Giardia* cases and 28% of all *Shigella* cases in the City. Youth ages 19 to 24 comprised a smaller proportion of cases of these four communicable diseases compared to children from ages 0 to 18.

### **Tuberculosis**

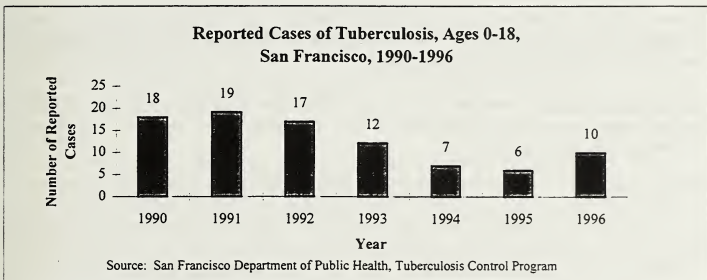
Tuberculosis, or TB, is a disease that usually attacks the lungs, and was once the leading cause of death in the U.S. Following improved standards of living and the discovery in the 1940s of several drugs to

treat the disease, TB slowly began to disappear in the U.S., but began to reemerge in the 1980s. TB is spread through the air from one person to another. However, many people who have TB infection never develop the disease. In some people, especially those who have weak immune systems, the bacteria becomes active and causes TB disease.

TB in San Francisco is a serious problem, mainly among the adult population, with TB case rates 4 times the national rate and double the California rate. HIV, substance abuse, poverty, homelessness, and the large number of foreign-born residents from high-incidence areas.

From 1990 through 1996, there were 89 new reported cases of active tuberculosis (TB) among children and youth ages 0 to 18 in San Francisco, or about 4% of the 2,189 cases in the City. San Francisco is similar to the nation in having a small percentage of all TB cases occurring among children. TB in a child is usually found after first discovering a case in an adult with whom the child has close contact.<sup>8</sup>

Citywide, the number of new cases of TB is decreasing, among both children and adults. San Francisco's decrease in TB cases parallels trends in both California and the U.S. in which the number of new cases has declined each year since 1994. The reduction in new cases of TB is attributed to efforts to target the population in which TB is being transmitted. The ten new cases in San Francisco children and youth ages 0 to 18 in 1996 represents a 44% decline from 1990 (18 cases), and compares to a decline of 21% of cases among individuals ages 19 and over (251 in 1996; 316 in 1990).

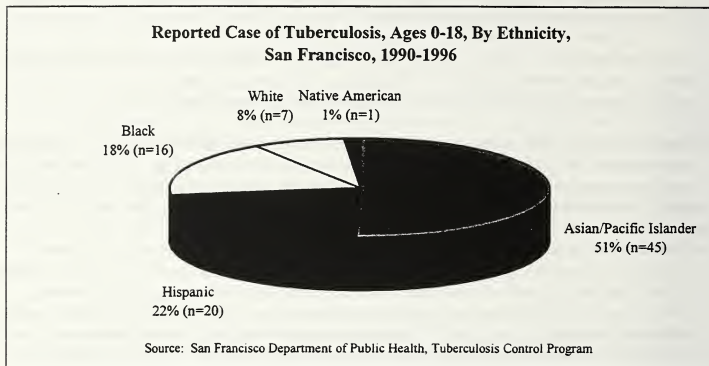


**By Age Group.** During the seven-year period, infants and young children up to age 5 represented 43% (39) of the cases, children ages 6 to 12 represented 21% (19) of cases, and youth ages 13 to 18 represented 35% (31) of cases. In 1996, San Francisco children under age 15 and youth ages 15 to 24 experienced the lowest rates of TB (94.5 and 12.1 per 100,000 respectively in 1996), compared to other age groups (42.7 to 65.1 per 100,000 for ages 25 and older).<sup>9</sup>

<sup>8</sup> Khan, Ejaz A., and Starke, Jeffrey R., "Diagnosis of Tuberculosis in Children: Increased Need for Better Methods," *Emerging Infectious Diseases*, Vol. 1 (4), October-December 1995.

<sup>9</sup> San Francisco Department of Public Health, TB Control Division. *Tuberculosis in San Francisco, 1996*. There are no Healthy People 2000 objectives specifically for the children and youth population. Healthy People 2000 objective 20.4 is to reduce TB to an incidence of no more than 3.5 cases per 100,000 people (all ages). Subobjectives include 20.4a for Asians/Pacific Islanders 15; 20.4b for Blacks 10; 20.4c for Hispanics 5; and 20.4d for American Indians/Alaska Natives 5.

By Race/Ethnicity. Pediatric TB rates between 1990 and 1996 among non-White racial/ethnic minorities were substantially higher than non-Hispanic whites. Nearly all (92%) new TB cases



reported among children and youth were in non-White racial/ethnic groups. About half (51%) of new pediatric TB cases were among Asian/Pacific Islanders, while Hispanics and African Americans comprised an additional 40% of reported cases.

By Foreign-Born Status. Over half (53%) of new active cases of TB among children and youth were among foreign-born residents (Philippines, 16 cases; Central and South America, 15; Southeast Asia, 9; China and Hong Kong 5; Africa 2).

## SEXUALLY TRANSMITTED DISEASES

### Overview

Sexually transmitted diseases (STDs) have serious health effects and can lead to impaired fertility and adverse pregnancy outcomes such as low birthweight and prematurity. Women and children suffer disproportionately from STDs and their complications. STDs also disproportionately affect poor people, youth, and racial/ethnic minorities, compared to the population as a whole. STDs and HIV infection are linked by common underlying risk behaviors. The presence of STDs has been shown to biologically increase the transmission and acquisition of HIV infections.<sup>10</sup>

Nationally, two-thirds of STD cases occur among young people under age 25 (excluding HIV infection).<sup>11</sup> Compared to older adults, adolescents (ages 10 to 19) and young adults (ages 20 to 24) are at higher risk for acquiring STDs for a number of reasons: they may be more likely to have multiple sexual partners rather than a single, long-term relationship, they may be more likely to engage in unprotected intercourse, and they are more likely to experiment with alcohol and drugs resulting in an increase in risk-taking behaviors including unsafe sex. In addition, there are biological reasons why young women are more susceptible to STDs than older women. Furthermore, the higher prevalence of STDs among adolescents reflects multiple barriers to STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with services designed for adults, and concerns about confidentiality.<sup>12</sup>

This section of the report will focus on three of the most commonly reported STDs including chlamydia, gonorrhea, and early syphilis. For each of these STDs, the overall rates by age group will be covered followed by rates by gender, race/ethnicity, and zip code for each STD. Refer to the "HIV/AIDS" and "Sexual Behavior" sections of this report which includes information closely related to information about STDs covered in this section.

### Data Source

Data for this section was obtained from the San Francisco Department of Public Health, STD Prevention and Control Program. California State law requires reporting of STDs to the local health department by all health care providers, including private physicians, hospitals, and clinics, and laboratories which perform STD testing.<sup>13</sup> In practice, many STD diagnoses go unreported. Furthermore, many people with STDs are never diagnosed, because they do not have access to health care, do not recognize their symptoms as an STD, or do not develop symptoms at all. For these reasons, reported totals should be considered minimal estimates of the true number of STDs in the community.<sup>14</sup> Also note that the number of reported cases may not equal the number of people with STD, since one person may account for more than one case during the reporting period.

<sup>10</sup> U.S. Department of Health and Human Services, Public Health Service, Healthv People 2000 Midcourse Review and 1995 Revisions

<sup>11</sup> U.S. Department of Health and Human Services, Public Health Service, Healthv People 2000 Midcourse Review and 1995 Revisions

<sup>12</sup> U.S. Department of Health and Human Services, Public Health Service, Division of STD Prevention, Sexually Transmitted Disease Surveillance, 1996. Atlanta: Centers for Disease Control and Prevention, September 1997.

<sup>13</sup> Providers and labs are required to report the patient's name, address, and demographic information (gender, age, and race /ethnicity). In 1996, the list of reportable STDs included syphilis of any stage, gonorrhea, chlamydia, chancroid, pelvic inflammatory disease (PID), and non-gonococcal urethritis (NGU).

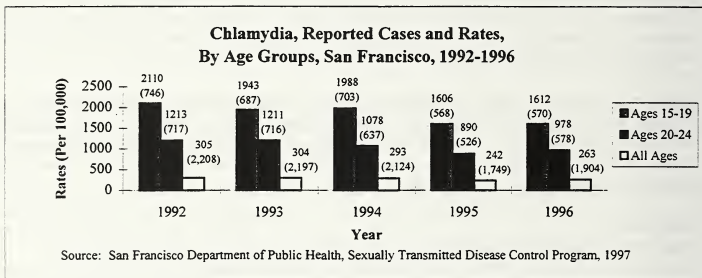
<sup>14</sup> STD rates in this report are equal to the number of STD cases within the specified population per 100,000 San Francisco residents in that population per year. Population figures for rates are from the 1990 U.S. Census.

## STDs in San Francisco

STD rates are highly correlated with age. Youth ages 15 to 19 have the highest rates of both chlamydia and gonorrhea, two of the most commonly occurring STDs, compared to all other age groups.

**Chlamydia.** Chlamydia is the most commonly reported STD in San Francisco and the U.S. Untreated chlamydia can cause pelvic inflammatory disease (PID) in women of childbearing age which can result in ectopic pregnancy or infertility. Untreated chlamydia also increases the risk of HIV transmission and acquisition. In addition, because chlamydia frequently occurs without symptoms, women are less likely to seek care, increasing the likelihood of adverse health outcomes due to lack of treatment.

In 1996, there were 570 cases of chlamydia among 15 to 19 year olds in San Francisco, a rate of 1,612 per 100,000 per year, and 578 cases among 20 to 24 year olds, a rate of 978 per 100,000 per year. In 1996, the rate among 15 to 19 year olds was over six times the rate for all age groups, while the rate among 20 to 24 year olds was 3.7 times the rate for all age groups. Chlamydia cases among 15 through 24 year olds represented over 60% of all cases in the City from 1992 to 1996.

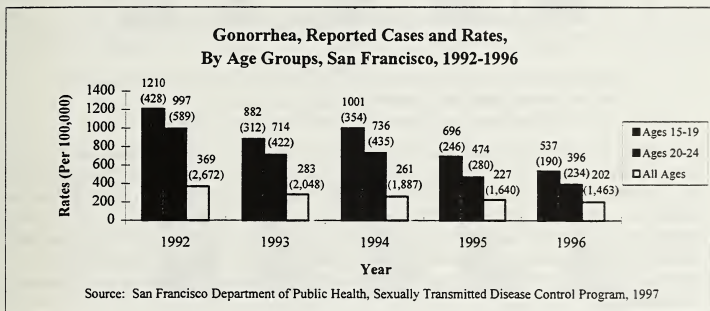


From 1992 to 1996, chlamydia rates declined by about 20% for 15 to 19 year olds, compared to a 14% citywide decline. Chlamydia rates for San Francisco as a whole are much higher than the rates for the U.S. and for California (1995). Chlamydia rates among both 15 to 19 year olds and 20 to 24 year olds increased slightly in 1996 compared to 1995. This increase coincided with and may be a result of implementation of a more sensitive urine-based test that allows for expanding screening to asymptomatic males and females.

**Gonorrhea.** Gonorrhea is the second most frequently reported communicable disease in San Francisco and the U.S., and its incidence is used as the key indicator of progress in reducing STDs. San Francisco's overall gonorrhea rates are higher than California (1995) and U.S. (1994) rates. Like chlamydia, untreated gonorrhea can result in infertility in women and increased transmission and acquisition of HIV in both men and women. However, symptoms of gonorrhea are usually more apparent than chlamydia, which increases the likelihood of treatment and prevention of adverse health outcomes.

In 1996, there were 190 cases of gonorrhea among 15 to 19 year olds in San Francisco (537 per 100,000), and 234 cases among 20 to 24 year olds (396 per 100,000). The gonorrhea rate among 15 to 19 year olds was close to three times the rate for all age groups (202 per 100,000), while the rate among 20 to 24 year olds was almost twice the rate for all age groups. From 1992 to 1996, gonorrhea cases among 15 to 19 and 20 to 24 year olds represented 16% and 20%, respectively, of all gonorrhea cases in the City.

Gonorrhea rates in all age groups are declining citywide. This parallels decreases seen in these other urban areas and for the U.S. as a whole.<sup>15</sup> In 1996, 15 to 19 year olds experienced the greatest decrease in gonorrhea compared of all the age groups. For the second consecutive year, cases in this age group decreased at least 20%. However, the rate still greatly exceeds the Healthy People 2000 objective of 375 per 100,000 for adolescents.<sup>16</sup> San Francisco has made progress toward but has yet to achieve the Healthy People 2000 goal of 100 cases per 100,000.



**Early Syphilis.** Early syphilis refers to cases of syphilis of less than one year's duration that are possibly still infectious. Early syphilis is a serious health concern for two major reasons, including increased risk of HIV transmission due to syphilis and the possibility that the infection can be passed on from a pregnant woman to her fetus, causing congenital syphilis in the infant, stillbirths, and other serious congenital problems.

In 1996, there were 5 cases of early syphilis among adolescents and young adults ages 15 to 24 in San Francisco, or 11% of the City's total of 44 reported cases.<sup>17</sup> The rate of early syphilis for 15 to 24 year olds was similar to the rate for all ages (6 per 100,000 persons per year). Early syphilis generally peaks among 30 to 34 year olds.

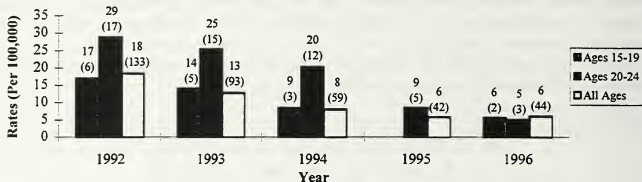
<sup>15</sup> San Francisco Department of Public Health, Division of Sexually Transmitted Disease Control, San Francisco Sexually Transmitted Disease Annual Summary, 1995, October 1996

<sup>16</sup> This is the only Healthy People 2000 objective pertaining specifically to STDs among adolescents (19.1a). Additional Healthy People 2000 objectives for STDs refer to the population as a whole, or other target populations.

<sup>17</sup> Syphilis in other stages such as late latent, latent of unknown duration, tertiary, neurosyphilis, and congenital syphilis are also required to be reported to local health authorities.

From 1992 to 1996, the occurrence of early syphilis declined by at least two-thirds for all age groups. Early syphilis rates for San Francisco as a whole are higher than statewide rates (1994) but lower than the U.S. rate (1995). Decreases seen in San Francisco have been much greater than those seen in other urban areas such as Los Angeles and New York City.<sup>18</sup>

**Early Syphilis, Reported Cases and Rates,  
By Age Groups, San Francisco, 1992-1996**



Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997  
There were zero cases among 15 to 19 year olds in 1995.

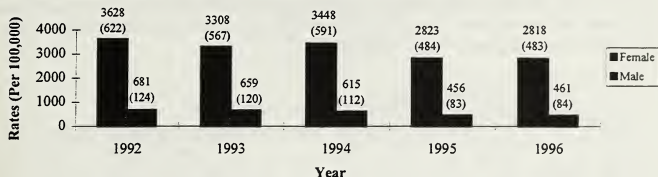
**By Gender.** Rates for chlamydia, gonorrhea, and early syphilis are higher for female adolescents than for male adolescents, with the greatest gender differences seen in chlamydia rates. In contrast, rates for gonorrhea and syphilis in adults are higher among men, although chlamydia rates in adults are also higher among women.<sup>19</sup> Part of the differences in incidence rates by gender may be due to screening efforts, which have traditionally focused on detecting infections among young women, especially for chlamydia, because of adverse reproductive outcomes of untreated infection (such as pelvic inflammatory disease) and also because there has been no convenient test to screen asymptomatic men for chlamydia.<sup>20</sup>

<sup>18</sup> San Francisco Department of Public Health, Division of Sexually Transmitted Disease Control, San Francisco Sexually Transmitted Disease Annual Summary, 1995, October 1996

<sup>19</sup> Healthy People 2000 Objective: Reduce gonorrhea rates for women ages 15 to 44 to 175 cases per 100,000 women. In 1995, San Francisco's rate (263) exceeded this objective.

<sup>20</sup> San Francisco Department of Public Health, Division of Sexually Transmitted Disease Control, San Francisco Sexually Transmitted Disease Annual Summary, 1995, October 1996

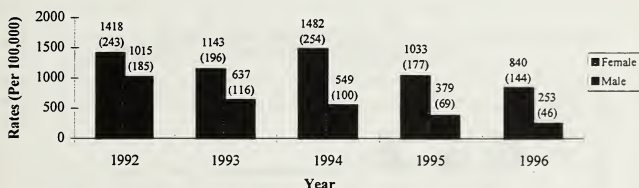
**Chlamydia, Reported Cases and Rates,  
Ages 15 to 19, By Gender, San Francisco, 1992-1996**



Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

From 1992 through 1996, females represented two-thirds of all gonorrhea cases (1,014 of 1,530) and over 80% of chlamydia cases (2,747 of 3,274) among 15 to 19 years olds. In 1996, the gonorrhea rate

**Gonorrhea, Reported Cases and Rates,  
Ages 15 to 19, By Gender, San Francisco, 1992-1996**



Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

for female adolescents was over three times the gonorrhea rate for male adolescents, and the chlamydia rate for female adolescents was over six times the chlamydia rate of male adolescents. Gonorrhea in adolescents has decreased since 1992, although by a greater proportion for males (75%) than females (41%). The rate of chlamydia also decreased in adolescents since 1992, by 32% for males and 22% for females.

With only a few recent cases of early syphilis among adolescents, analysis of early syphilis gender trends is difficult. The number of cases declined from 6 in 1992 to 5 (1993), 3 (1994), none (1998), and 2 in 1996.

**By Race/Ethnicity.** Chlamydia and gonorrhea rates for San Francisco adolescents ages 15 to 19 of all race/ethnic groups have generally declined since 1992. African Americans had the highest rate of chlamydia and gonorrhea, followed by Native Americans, Hispanics, Whites, and Asian/Pacific

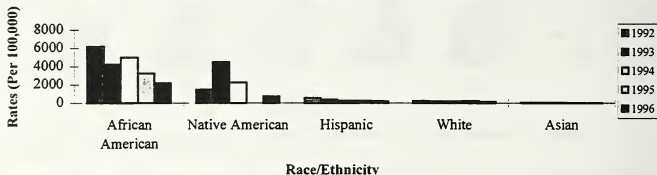
Islanders. This relative order is the same for adult cases.<sup>21</sup> From 1992 through 1996, African Americans accounted for 47% of all adolescent chlamydia cases (2,747 of 3,274) and 70% of all adolescent gonorrhea cases (1,066 of 1,530). While the rate for African Americans has declined since 1992 for both chlamydia and gonorrhea, African American adolescents still have a gonorrhea rate over four times the average gonorrhea rate for all San Francisco adolescents and three times the average chlamydia rate for all San Francisco adolescents.

**Chlamydia Rates, Ages 15 to 19,  
By Race/Ethnicity, San Francisco, 1992-1996**



Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

**Gonorrhea Rates, Ages 15 to 19,  
By Race/Ethnicity, San Francisco, 1992-1996**



Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

With only few cases of early syphilis among adolescents (16 total cases including 6 African American, 5 Hispanic, 4 White, and 1 Native American), analysis of race trends is difficult because of large swings in race-specific incidence rates.

By Geographic Area. From 1992 to 1996, 80% of gonorrhea and 74% of chlamydia cases among youth ages 15 to 19 in San Francisco were among residents of ten zip codes in the City. The Bayview

<sup>21</sup> With the exception that chlamydia rates for Asian adults are higher than rates for whites.

**SEXUALLY TRANSMITTED DISEASES,  
REPORTED CASES,  
AGES 15-19, BY ZIP CODE,  
SAN FRANCISCO, 1992-1996**

		Total Reported Cases, 1992-1996					
<u>Zip Code</u>	<u>Area/Neighborhood</u>	Gonorrhea		Chlamydia		Early Syphilis	
		#	%	#	%	#	%
94124	Bayview Hunters Point	400	26%	616	19%	2	13%
94110	Inner Mission/Bernal Hts	160	10%	324	10%	3	19%
94134	Visitation Valley/Sunnydale	128	8%	378	12%	3	19%
94112	Ingle/Exels'r/Crocker-Amazon	111	7%	207	6%	0	0%
94115	Western Addition/Japantown	97	6%	321	10%	0	0%
94102	Tenderl'n/Hayes Val'y/N. of Mkt	89	6%	150	5%	0	0%
94117	Haight-Ashbury	80	5%	127	4%	1	6%
94107	Potrero Hill	78	5%	112	3%	1	6%
94103	South of Market	44	3%	99	3%	0	0%
94132	Lake Merced	35	2%	81	2%	0	0%
Other	All Other Areas/Neighborhoods	308	20%	859	26%	6	38%
	Total	1,530	100%	3,274	100%	16	100%

Hunters Point neighborhood (zip code 94124) had the highest number of both gonorrhea and chlamydia cases among adolescents, with Visitation Valley/Sunnydale (94134) and Inner Mission/Bernal Heights (94110) either second or third highest for gonorrhea and chlamydia.<sup>22</sup> The geographic distribution of STD cases among adolescents is similar to the geographic distribution of adult cases.

<sup>22</sup> Data on rates by zip codes is not available because of the small population size per zip code area.

## HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a specific group of diseases or conditions related to infection by the human immunodeficiency virus (HIV). HIV causes severe weakening of the body's immune system.<sup>23</sup> A person who is infected with HIV is referred to as being HIV-infected or "HIV-positive," and may or may not have AIDS. Since the epidemic began in 1981, deaths from AIDS increased annually, and by 1994 became the leading cause of death for younger adults in the U.S.

HIV is spread through sexual contact with an infected person, by needle-sharing among injecting drug users, or, very rarely through transfusions of infected blood or blood clotting factors. Infants born to HIV-infected women may become infected before or during birth, or through breast-feeding after birth. Currently in California, reporting of AIDS cases is mandatory, and reporting of HIV is not.<sup>24</sup>

Adolescents (both within and out of school) and young adults are considered to be at "high-risk" for HIV infection since many of them engage in behaviors that increase the likelihood of acquiring and transmitting AIDS.<sup>25</sup> As part of the normal developmental process, youth experience rapid physical, cognitive, and sexual changes that can be confusing. This developmental process often involves substance use and exploration of sexuality which may be greatly influenced by peer pressure. Young people may also experience feelings of isolation, anger, and low self-esteem that lead to risk-taking. These issues are particularly relevant in certain San Francisco youth populations, namely young men having sex with men (gay/bisexual youth), youth who exchange sex for money or drugs, injection drug users, and new immigrants.<sup>26</sup>

Currently, there is no treatment available to cure AIDS, although new and promising drug treatments have extended survival among those who are HIV-infected and have resulted in dramatic reductions in both new cases of AIDS and deaths due to AIDS. Because of the long latency period between HIV infection and the development of AIDS, it is likely that people who are diagnosed with AIDS between the ages of 20 and 29 were infected when they were teenagers. We therefore cover in this section the occurrence of HIV and AIDS among people up to the age of 29.

### HIV

Unlike AIDS, HIV infection is currently not a reportable condition in California. Therefore, HIV prevalence in the state and county can only be estimated. In May 1997, the San Francisco Department of Public Health convened a panel of local experts in HIV and AIDS research to arrive at a consensus on HIV prevalence and incidence in San Francisco.<sup>27</sup> The meeting resulted in an estimate that 15,249

<sup>23</sup> The definition for AIDS is established by the federal Centers for Disease Control. The definition for adolescents and adults was expanded in 1993 to include new laboratory test criteria and indicator diseases. Pediatric AIDS cases were not affected by the new criteria.

<sup>24</sup> AIDS must be reported in the U.S.; HIV infection is not reportable uniformly throughout the U.S. The reported number of AIDS cases does not include those who are HIV-infected, but have not yet progressed to AIDS.

<sup>25</sup> U.S. Department of Health and Human Services, *Healthy People 2000* [original book]

<sup>26</sup> Givertz, Daniel and Mitchell Katz. San Francisco Department of Public Health, AIDS Office and Special Programs for Youth, *Youth and HIV Disease in San Francisco*, May 1993

<sup>27</sup> The prevalence of HIV was defined as the proportion of the total risk population infected with HIV in 1997. The incidence of HIV was defined as the proportion of the susceptible (uninfected) population acquiring HIV infection in 1997.

persons were living with HIV in San Francisco, representing 2% of the City's population.<sup>28</sup> The majority of HIV infections (86%) were among men who have sex with men, the population which continues to be the most severely affected by the epidemic in San Francisco (MSM), followed by injecting drug users (IDUs) (10%), and heterosexual men and women (3%). The panel estimated that 500 new HIV infections will occur in 1998, mainly among MSM (67%) and IDUs (24%).<sup>29</sup>

The consensus panel developed estimates of HIV infection for selected risk populations, including MSM Non-IDU age 29 and under and infants and children age 13 and under. HIV prevalence (number of HIV-infected individuals in a population) among MSM Non-IDU age 29 and under was estimated at 15% (945 persons) or about half the rate of older (age 30 and above) MSM (33%) (10,755). HIV incidence (number of new cases of HIV infection) among MSM Non-IDU age 29 and under was estimated at 1.2% per year (64 persons) slightly higher than the incidence for MSM Non-IDU age 30 and above of 1.0% (53 persons).

**Estimated HIV Incidence and Prevalence,  
Selected Risk Groups,  
San Francisco, 1997**

<u>Risk Group</u>	<u>Population</u>	<u>Prevalence</u>		<u>Incidence</u>	
	<u>Size</u>	<u>#</u>	<u>%</u>	<u>#</u>	<u>%</u>
MSM <= Age 29	6,300	945	15%	64	1.2%
Infants/Children <= Age 13	10,500	66	0.06%	1	0.001%

Source: San Francisco Department of Public Health, HIV Seroepidemiology Unit, 1997 HIV Consensus Report on HIV Prevalence and Incidence in San Francisco

The consensus estimate for the number of infants and children living with HIV in San Francisco in 1997 was 66 (0.06%). Approximately ten HIV-positive pregnant women give birth in San Francisco each year. Considering the known rate of mother-to-child transmission combined with the availability of treatment to interrupt transmission, the consensus group estimated that one infant born in San Francisco each year (0.001%) will become HIV-infected out of approximately 8,000 to 9,000 births.

<sup>28</sup> Shafer, Kimberly Page, William McFarland, and Mitchell H. Katz, San Francisco Department of Public Health, HIV Seroepidemiology Unit, 1997 HIV Consensus Report on HIV Prevalence and Incidence in San Francisco

<sup>29</sup> Healthy People 2000 objective 18.2 is to slow the rise in prevalence of HIV infection to 400,000 per 100,000, with total U.S. case targets for MSM, IDUs, and females giving birth to live-born infants.

By Race/Ethnicity. The largest proportion (67.6%) of MSM (non-IDU) under age 30 were white (639), followed by 12.0% Latino (113), 9.5% African American (90), 9.5% Asian/Pacific Islander (90), and 1.4% "other" (13). A larger proportion of MSM (non IDU) under age 30 were non-white (32.4%) compared to older MSM (non-IDU) (age 30 and over) (23.0%).

<b>Estimated HIV Prevalence, Selected Risk Groups, By Race/Ethnicity, San Francisco, 1997</b>				
	MS M < Age 30		Infants/Children <= Age 13	
	#	%	#	%
White	639	67.6%	28	42.4%
African-American	90	9.5%	23	34.8%
Latino	113	12.0%	8	12.1%
Asian/PI	90	9.5%	3	4.5%
Other	13	1.4%	4	6.1%
Total	945	100.0%	66	100.0%
Source: San Francisco Department of Public Health, HIV Seroepidemiology Unit, <u>1997 HIV Consensus Report on            HIV Prevalence and Incidence in San Francisco</u>				

Whites comprise the largest proportion of infants and children age 13 and under with HIV infection at 42.5% (28), followed by African American 35% (23), Latino 12.5% (8%), Asian/Pacific Islander 5% (3), and "other" 5% (3).

## AIDS

Only a portion of individuals with HIV infection are diagnosed with AIDS. As previously noted, AIDS is a reportable condition in California and the definition of AIDS is established by the federal Centers for Disease Control.

AIDS in San Francisco, All Ages. San Francisco has a large number of residents who are diagnosed with AIDS relative to the total population. The average of 2,959 cases per 100,000 residents is the highest rate in the state and 4<sup>th</sup> among U.S. metropolitan areas with populations of 500,000 or more. San Francisco is second to Los Angeles County in the total reported AIDS cases and total deaths due to AIDS. San Francisco's 22,460 reported cases represents 21% of the state's total. As of March 1998, 15,413 San Franciscans have died of AIDS. The high incidence of AIDS in San Francisco and throughout California greatly exceeds the national Healthy People 2000 goal of 43 AIDS cases per 100,000 people.<sup>30</sup> (Refer to the Appendix for detailed data.) As of June 1997, California was the

<sup>30</sup> Healthy People 2000 objective 18.1, referring to AIDS case rates, does not include subobjectives referring to the children and youth population. Additional objectives specifically for adolescents include risk reduction objectives (e.g. reduction in sexual intercourse) and services and protection objectives (e.g. HIV prevention education in schools).

fourth highest ranking state in the U.S. in the number of cases of AIDS among children less than 13 years old (549).<sup>31</sup>

The populations most severely affected by AIDS in San Francisco differ greatly from the U.S. as a whole. Most cases of AIDS in San Francisco, which has a large gay population, are among men who have sex with men (MSM) (80%), compared to 49% in the U.S. as a whole. In San Francisco, MSM who also inject drugs (MSM+IDU) is the second largest transmission group (10%), followed by heterosexual IDUs (6.5%) (through March 1998). This compares to the U.S. overall in which MSM+IDU account for 6% of AIDS cases and heterosexual IDUs account for 26% of AIDS cases. AIDS transmission through heterosexual contact accounts for 9% of U.S. cases and only 2% of San Francisco cases (through June 1997).

A total of 858 cases have been reported among females in San Francisco, or 3.4% of the City's total AIDS cases (through March 1998). Nationally, females represent a substantially larger proportion (16%) of AIDS cases (through June 1997). Whites represent less than one-third of the City's population, but represent 75% of the City's AIDS cases (18,983). In San Francisco, AIDS cases up to age 13 represent only 0.2% (42) of all cases to date, compared to 1.3% nationally.

Trends. In San Francisco and throughout the U.S., persons with AIDS are living longer as both the number of new cases and the number of deaths declines. Experts attribute the decline in cases and deaths to the use of new anti-viral drugs, in combination with prevention efforts (behavior modification) which has reduced the infection rate, especially among gay men. However, young gay men continue to have high rates of HIV infection and risk behaviors.

0 to 29 Age Group. As of March 1998, 3,045 children, youth, and young adults in San Francisco up to age 29 were reported to have AIDS. These cases represent 12% of all AIDS cases in the City, a smaller proportion than the U.S. average (19%) for the same age group.<sup>32</sup>

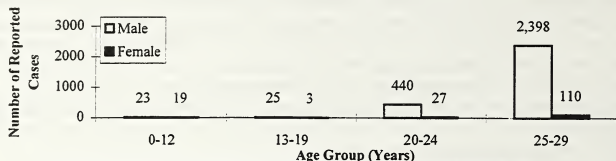
Among those up to 29 years of age, a majority (82%), or 2,508 of cases are concentrated in the 25 to 29 age group, and males (2,886) account for 95% of cases.

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<sup>31</sup> Following New York (2,008 cases), Florida (1,270), and New Jersey (693).

<sup>32</sup> Through March 1998 for San Francisco, and through June 1997 for U.S.

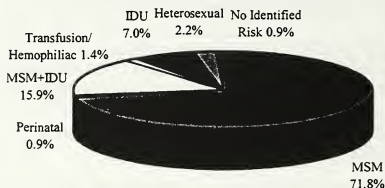
**AIDS Reported Cases, By Gender, By Age Groups (0-29),  
San Francisco, Reported Through March 31, 1998**



Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, AIDS Surveillance Report, April 1998

Similar to the citywide pattern of AIDS, most cases (71.8%; 2,185) within the 0 to 29 age group are among men having sex with men (MSM) or combined MSM and IDU (15.9%; 483).

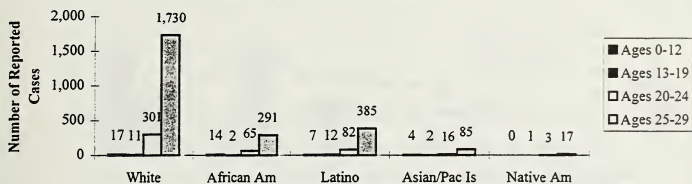
**AIDS Reported Cases, Ages 0-29, By Transmission Category,  
San Francisco, Reported Through March 31, 1998**



Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, Special Report, April 1998

Whites account for over two-thirds (68%) of all AIDS cases up to age 29 (2,059 cases), and represent the largest number of cases within all age groups. Following whites are Latinos (16%; 486), African Americans (12%; 372), Asian/Pacific Islanders (3%; 104), and American Indian/Alaskan Natives (1%; 21).

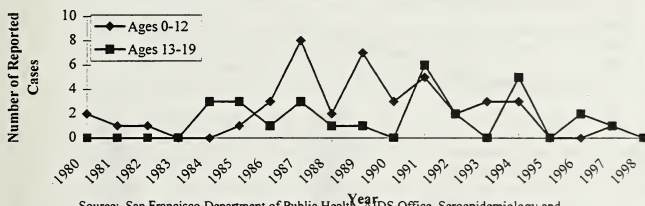
### AIDS Reported Cases, Ages 0-29, By Race/Ethnicity, San Francisco, Reported Through March 31, 1998



Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, *AIDS Surveillance Report*. Through March 1998

**Trends.** Similar to the City as a whole, the number of AIDS cases in the 0 to 29 age group is declining, most notably in the 20 to 24 and 25 to 29 age groups. The number of annual new cases of AIDS among children ages 0 to 12 has remained at zero or one since 1995, compared to a high of eight cases in 1987. The number of new cases among children and youth ages 13 to 19 peaked in 1991 (6) and 1994 (5), compared to a maximum of two cases per year since 1995.

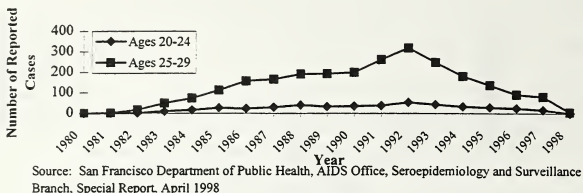
### AIDS Incidence (Reported Cases), By Age Group (Ages 0-19), 1980-1998, San Francisco, As of March 31, 1998



Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, *Special Report*, April 1998

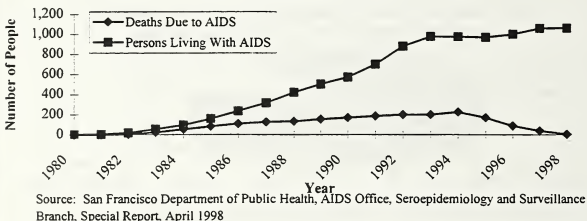
The number of new cases of AIDS among young adults ages 20 to 24 and ages 25 to 29 peaked in 1992 (54 and 321 cases, respectively), and has dropped for five consecutive years, to only 17 and 82 cases (data for 1998 are still incomplete). These are declines of 68% and 75% respectively, since 1992.

**AIDS Incidence (Reported Cases), By Age Groups (Ages 20-29),  
1980-1998, San Francisco, As of March 31, 1998**



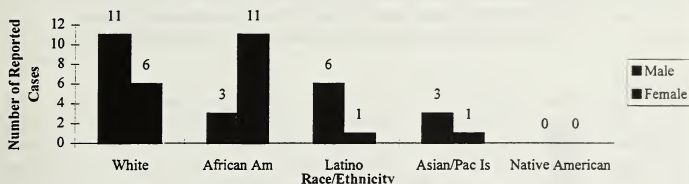
Through March 1998, a total of 1,979 San Franciscans up to age 29 have died of AIDS, representing 11.5% of all AIDS deaths (17,198) in the City. The number of San Franciscans up to age 29 dying of AIDS is also declining, by 82% since 1994 (from 226 deaths in 1994 to 40 in 1997). There is a concurrent rise in the number of persons living with AIDS (1,065 as of March 1998).

**AIDS Mortality and Prevalence, Ages 0-29, 1980-1998,  
San Francisco, As of March 31, 1998**



0 to 12 Age Group. Among San Francisco infants and children up to 12 years old, two-thirds of AIDS cases (27 cases) reported from 1980 through March 31, 1998 were contracted through perinatal transmission and one-third (15) were due to transfusion/hemophiliac, for a total of 42 cases in San Francisco for this age group. More males (13 cases) than females (fewer than five cases) contracted AIDS as a result of transfusion/hemophilia; males may have more exposure since certain diseases of the blood requiring blood product transfusions are generally passed on genetically through males.

**AIDS Cases, Ages 0-12, By Race/Ethnicity and Gender,  
San Francisco, Reported Through March 31, 1998**

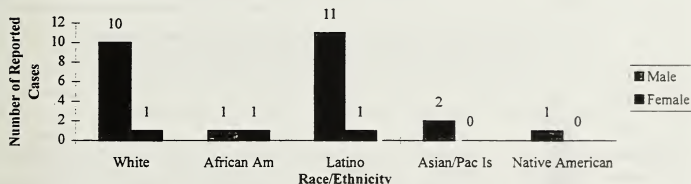


Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, AIDS Surveillance Report, Through March 1998

Whites account for two-thirds (10 of 15 cases) of transfusion/hemophiliac cases. Nearly all cases among females up to age 12 (89%; 17 cases) were due to perinatal transmission. Perinatal transmission was most common among African Americans and Latinos, accounting for over 86% of cases within these two racial/ethnic groups.

13 to 19 Age Group. Twenty-eight cases of AIDS have occurred among San Francisco youth 13 to 19 years of age, with nearly all cases (25 of 28 cases) occurring among males, and over half (54%; 15 cases) within the men having sex with men (MSM) category. The second largest risk category within

**AIDS Reported Cases, Ages 13-19, By Race/Ethnicity and Gender,  
San Francisco, Reported Through March 31, 1998**

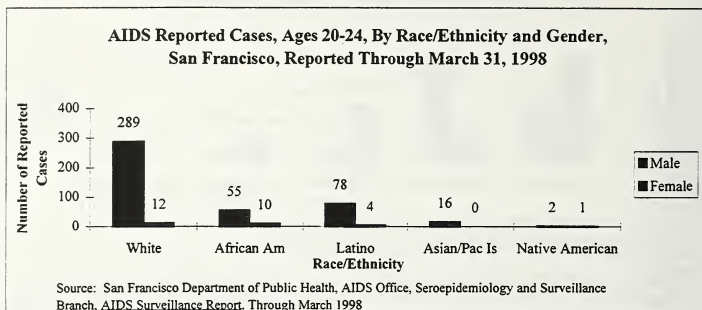


Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, AIDS Surveillance Report, Through March 1998

this age group was transfusion/hemophiliac (21%; 6 cases). Most (84%; 21 cases) males ages 13 to 19 were White or Latino.

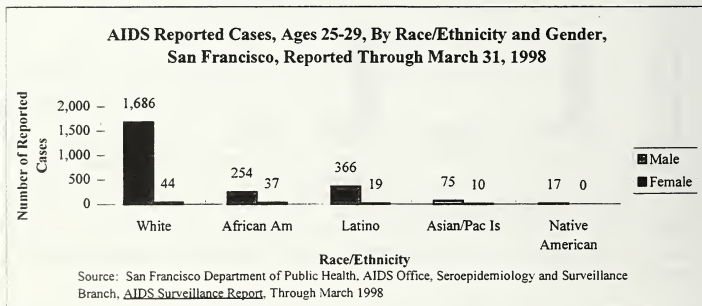
20 to 24 Age Group. There were 467 AIDS cases in the 20 to 24 year old age group, with MSM transmission accounting for two-thirds (65%; 305 cases) of cases. An additional 29% of cases due to the combined MSM and IDU risk group (94) or injection drug use only (43). Females account for less

than 6% of cases in this age group (27), with nearly equal occurrence due to IDU (12) and heterosexual contact (13).



Whites account for two-thirds of cases (64%; 301 cases) in this age group, followed by Latinos (17.5%; 82), African Americans (14%; 65), Asian/Pacific Islanders at (3%; 16), and Native Americans (<1%; 3). The MSM risk factor predominates in all ethnic groups, followed by the combined MSM and IDU category, and together accounted for 85% (399) of all cases in this age group.

25 to 29 Age Group. Through March 1998, there were a total of 2,508 reported cases of AIDS among the 25 to 29 age group, with nearly all (97%; 2,398) cases among males. Nearly all cases within this age group are associated with MSM or IDU-related risk factors (74% MSM; 15% MSM and IDU; 7% IDU). IDU is the primary mode of transmission among females, accounting for about half of the 58



cases followed by heterosexual contact (41 cases). Whites comprised 69% of cases, followed by Latinos (15%), African Americans (12%), Asian/Pacific Islanders (3%), and American Indian/Alaska Native (0.7%).

## MENTAL HEALTH

Mental health refers to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioral incapacity. Mental health and mental disorders can be affected by numerous factors including biologic, genetic, physical, and environmental conditions.<sup>1</sup>

Children and youth experiencing mental health problems can be withdrawn, anxious or depressed, show aggressive or delinquent behaviors or have attention or thought disorders. Children with unrecognized or untreated cognitive and emotional disorders cannot learn adequately at school or benefit readily from the healthy peer and family relationships that are essential to becoming a healthy and productive adult. They are at heightened risk for school failure and dropping out, alcohol and drug use, unsafe behaviors for HIV transmission, criminal involvement, and many other problems.<sup>2</sup> Major depression, if untreated, is a strong risk factor for attempted suicide in youth and adults.<sup>3</sup>

Nationally, an estimated two-thirds of all young people are not getting the mental health treatment they need.<sup>4</sup> Many children and youth do not have their mental health needs identified until they enter the juvenile probation or child welfare systems. Aggressive, acting out and delinquent behaviors are frequently the result of mental disturbance for children entering local juvenile probation programs. Nationally, it has been estimated that between 43 to 70% of abused and neglected children entering child welfare systems have mental health problems severe enough to warrant treatment.<sup>5</sup> In addition, an estimated 60% of teenagers in juvenile detention have behavioral, mental, or emotional disorders.<sup>6</sup>

### Data Sources

Data on the prevalence of mental disorders among the San Francisco child and youth population is limited. In order to provide some indication of the mental health status among the City's children and youth, this section includes data from the following sources:

- Deaths due to suicide for San Francisco residents, children and youth, ages birth to 24 from 1990 to 1995;
- Preliminary results of the 1997 San Francisco Youth Risk Behavior Survey (YRBS) conducted by the San Francisco Unified School District (in conjunction with the federal Centers For Disease Control). The 1997 YRBS surveyed 1,783 public middle school (6<sup>th</sup> through 8<sup>th</sup> graders, ages 11 through 14 and older) and 1,914 public high school (9<sup>th</sup> through 12<sup>th</sup> graders, ages 15 to 18 and older).
- Demographic, utilization, and outcome data from the San Francisco Department of Public Health's Community Mental Health Services Division, Children, Youth, and Family Services Section,

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<sup>1</sup> U.S. Department of Health and Human Services, Healthy People 2000 Review 1995-96

<sup>2</sup> Hyman, S., National Institute of Mental Health. Testimony on Children's Health. Appropriations Subcommittee on Labor, Health and Human Services and Education, Washington, D.C.: October 29, 1997.

<sup>3</sup> National Mental Health Association. Adolescent Suicide: Helping Depressed Teens. Virginia: National Mental Health Association, 1997.

<sup>4</sup> Estimation Methodology for Children with a Serious Emotional Disturbance. Federal Register, October 6, 1997.

<sup>5</sup> Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

<sup>6</sup> Leiter, V. Special Analysis of Data from the Office of Juvenile Justice and Delinquency Prevention Conditions of Confinement Study, D.C.: Office of Juvenile Justice and Delinquency Prevention, 1993.

which provides mental health services to severely emotionally disturbed San Francisco children and youth who receive Medi-Cal and/or are indigent.

### **Prevalence of Mental Illness – National Estimates**

Various estimates suggest that up to 20% of children and adolescents throughout the U.S. suffer from serious diagnosable emotional or behavioral health disorders, which range from attention deficit disorder and depression to bipolar disorder and schizophrenia.<sup>7</sup> Data on the prevalence of mental illness for San Francisco children and youth are not available.<sup>8</sup>

### **Suicide and Depression**

**Suicides.** In the absence of data on prevalence of mental illness in the population, data on suicide deaths are often used to provide an indication of the prevalence of the most severe mental health problems within the population. From 1990 to 1995, suicide was the second leading cause of death for San Francisco youth ages 15 to 24 (65 deaths) and the fifth leading cause of death for children and youth for all ages up to age 24 (80 deaths). Nationally, suicide is the third leading cause of death for youth ages 15 to 24.

Healthy People 2000 objectives regarding suicide in the youth population focus on adolescents ages 14 to 19 and female adolescents ages 14 to 17. Comparable data for San Francisco in these gender and age groups to compare with Healthy People 2000 goals were not available for this report.<sup>9</sup> (Also refer to the “Mortality” section of this report and the Appendix for more detailed data on suicide.)

**Depression and Suicide-Related Thoughts and Behavior.** The 1997 San Francisco Youth Risk Behavior Survey provides data on the prevalence of depression and suicide-related thoughts and behaviors among public school students at the middle and high school levels.

In 1997, three-fourths (77%) of San Francisco middle school students said that they “felt sad and depressed” at least one day over the past 30 days, with two-thirds (61%) feeling sad and depressed from one to nine days, and 4% feeling sad and depressed for all 30 days. Female middle school students (83%) were more likely than male students (71%) to have felt sad and depressed.<sup>10</sup>

A quarter (24%) of San Francisco middle school students said that they had seriously thought about killing themselves, compared to one-fifth (20%) of high school students who had seriously considered suicide. This compares to the national average of 24% for all students. San Francisco females were more likely to have seriously considered attempting suicide than were males, in both middle school (29% vs. 19%) and high school (25% vs. 15%) levels. These proportions are similar to national results (30% vs. 18%).

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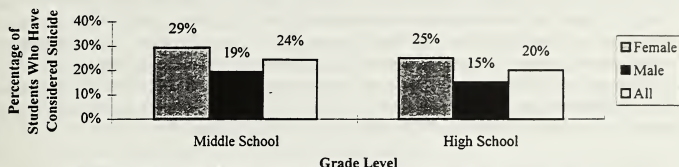
<sup>7</sup> Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

<sup>8</sup> Healthy People 2000 objective 6.3 seeks to reduce to less than 17% the prevalence of mental disorders among children and adolescents 18 years and under.

<sup>9</sup> Healthy People 2000 objectives related to suicide among youth include: To reduce suicides among adolescents ages 15 to 19 per 100,000 to 8.2 per 100,000 (objective 6.1a); to reduce suicide attempts among adolescents ages 14 to 17 to 1.8% (objective 6.2); and to reduce suicide attempts among female adolescents ages 14 to 17 to 2.0% (objective 6.2a).

<sup>10</sup> High school students were not asked this question; national data were not available.

**Percentage of Students Who Have Seriously Considered Suicide,\*  
Public Middle and High School Students, San Francisco, 1997**



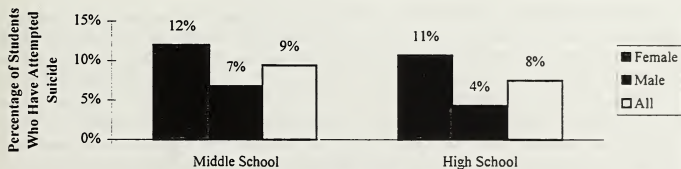
Source: San Francisco Unified School District, 1997 San Francisco Youth Risk Behavior Survey

Note: At any time in one's lifetime for middle school students; during the past 12 months for high school students.

In 1997, 13% of San Francisco middle school students had made suicide plan at least once, and 15% of San Francisco high school students had made a plan to kill themselves within the past 12 months. This compares to the overall national rate of 18%. Female students were more likely than male students to have made a plan to kill themselves, in both the middle (16% vs. 9%) and high school levels (18% vs. 12%), and also nationally (21% vs. 14%). In San Francisco, one of five (21%) 10th grade females had made a suicide plan.

In 1997, 9% of San Francisco middle school students said they had attempted suicide at least once in their lifetime, and 8% of high school students said that they had attempted suicide at least once within the past 12 months. Among high school students, 4% said they had attempted suicide at least twice, and 0.7% had attempted suicide 6 or more times (middle school students were not asked how many times they attempted suicide). Females were more likely than males to have tried to kill themselves, in both the middle school (12% vs. 7%) and high school (11% vs. 4%) levels. Nationally, females were also more likely than males (12% vs. 6%) to have attempted suicide.

**Percentage of Students Who Have Attempted Suicide,\*  
Public Middle and High School Students, San Francisco, 1997**



Source: San Francisco Unified School District, 1997 San Francisco Youth Risk Behavior Survey

Note: At any time in one's lifetime for middle school students; during the past 12 months for high school students.

## Community Mental Health Services

Effective treatments for children's psychiatric disorders typically require not only direct interventions such as psychotherapy or medication but also a range of other actions, including interventions with parents and school personnel.<sup>11</sup> Researchers and clinicians agree that "systems of care" are needed to coordinate public and community-based mental health services for children and their families. These systems of care should include mental health assessment, early intervention, crisis intervention, outpatient and inpatient care, day treatment, in-home services, intensive and ongoing case management, and family support. While private insurance has historically covered some limited mental health services (especially inpatient services for severe cases), public agencies have played the primary role in serving children with serious mental health problems.<sup>12</sup>

In 1984, California began testing the Systems of Care model which is now operational in most counties. San Francisco's Mental Health System of Care for children, youth, and their families has been operational since 1991 and has responded to child abuse and neglect referrals, psychotic episodes, criminal law violations, learning disabilities, and other pressing mental health needs of San Francisco children and youth. Demand for mental health services has grown as a result of increased child abuse reporting and increased felony arrests of juveniles ages 12 to 17, including arrests for violent crimes. (Refer to the "Child Abuse and Neglect" and "Crime" sections of this report for more detailed data on child abuse and arrests.)

The following sections provide demographic, utilization, and outcome data on clients served by the San Francisco Mental Health System of Care for children and youth administered by the Children, Youth and Family Services Section of Community Mental Health Services (CMHS) within the San Francisco Department of Public Health. The mission of the Children, Youth, and Family Services (CYFSS) section is to manage mental health care for seriously disturbed children and youth residents of San Francisco up to age 19 who receive Medi-Cal benefits and/or have limited or no resources. The CYFSS provides mental health services through a comprehensive, culturally competent, community-based system of care that is consumer-driven, outcome-oriented and focused on treating the whole child and the family. CYFSS's two primary objectives are first, to provide treatment services to children and youth with serious emotional problems through a culturally competent system of care, and second, to provide assistance to families and communities in creating support networks for high-risk children and youth and their families.

To achieve its mission, CYFSS works in collaboration with many child-serving public and private agencies to provide a broad spectrum of mental health services for children and youth within the "System of Care". This continuum of services include and are not limited to: prevention and early intervention programs (Primary Intervention Programs (PIP), Healthy Start and Early and Periodic Screening, Diagnoses and Testing (EPSDT)); early mental health consultation (childcare centers; family resource centers/networks); primary care consultation liaison services; neighborhood-based outpatient services; day treatment programs; crisis intervention teams; school based mental health care; intensive case management; wrap-around (individualized) services; residential and substance treatment programs; and hospitalization and post-transitional services.; and foster care mental health services.

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<sup>11</sup> Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

<sup>12</sup> Crowell, Areta, Emotional Health Services for Children, Youth: Coordinated Care, Insurance Coverage Needed. Sacramento: The California Center for Health Improvement, 1998.

(Refer to the Appendix for a detailed description of the San Francisco Mental Health System of Care for children and youth.)

Two recently implemented key initiatives involving CYFSS reflect CYFSS's direction for the future. As of April 1, 1998, CMHS Division of the San Francisco Department of Public Health (SFDPH), implemented Phase II of the State's Medi-Cal Mental Health Managed Care consolidation with the establishment of the San Francisco Mental Health Plan which includes CYFSS as part of the Plan. Under the Plan, the SFDPH assumes fiscal and management responsibility for all specialty mental health services for San Francisco Medi-Cal beneficiaries of all ages. Services are unchanged, except that a 24-hour, 7-day a week centralized intake unit with a toll-free number (1-888-246-3333) assists in providing more accessible, coordinated, and integrated services.

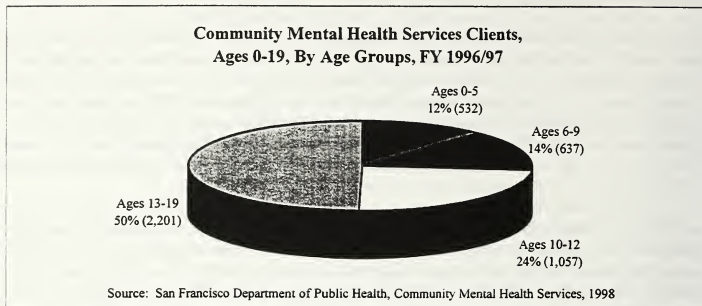
In 1997, CYFSS implemented a key initiative focusing on mental health services and juvenile justice-involved youth and their families. The initiative expanded San Francisco's Comprehensive Child Crisis Services to provide outreach and 24-hour accessibility to youth involved in or at risk for involvement in the juvenile justice system. The initiative provides a full range of mental health services from screening to assessment to medication case management of youth and their families. A comprehensive, multidisciplinary Youth Assessment Team at the Youth Guidance Center (Juvenile Hall) assess youth and develop a comprehensive mental health care plans for youth who are detained or being discharged from Juvenile Probation. The team, composed of representatives from Special Programs for Youth Health Services, Woodside Learning Center, Department of Human Services and Community Substance Abuse Services, collaborates in providing a coordinated care of plan.

Client Demographics and Baseline Data. The number of children and youth served by the Children, Youth, and Family Services Section has risen steadily since 1991, reaching 4,427 children and youth (unduplicated count) up to age 19 in FY 1996/97 (July 1 – June 30). The children and youth population comprised 22% of all CMHS clients (19,117). More male (59%; 2,603) than female (41%; 1,824) children and youth were served.<sup>13</sup>

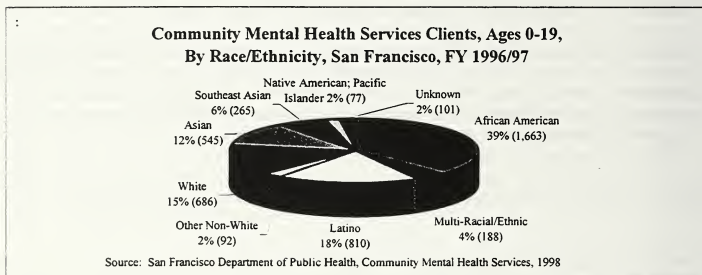
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<sup>13</sup> San Francisco Department of Public Health, Community Mental Health Services, Children, Youth, and Family Section, San Francisco County System of Care Implementation Proposal to the California Department of Mental Health, October, 1997.

*By Age.* In 1996/97, half (50%) of CMHS children and youth clients were ages 13 to 19.



*By Race/Ethnicity.* In FY 1996/97, African Americans comprised over one-third (38%) of children and youth clients followed by Latinos (18%), Whites (15%), Asians (12%), multi-racial/ethnic (4%), and others (16%).<sup>14</sup> African American children and youth comprise a disproportionate share of clients



compared to their proportion of the San Francisco child and youth population. Since 1991, the numbers of Asian Americans have risen at a higher rate than for all the major racial/ethnic groups. In 1991, Asian Americans were served in number equal to Whites. (Refer to the Appendix for detailed data.)

*By Zip Code of Residence.* In FY 96/97, the largest number of CMHS child and youth clients were residents of the eastern and southeastern half of San Francisco including: North Beach, South Beach, Tenderloin, Japantown, Western Addition, Civic Center, South of Market, China Basin, Potrero Hill,

<sup>14</sup> These are the race/ethnicity categories designated by Community Mental Health Services.

Outer Mission, Bernal Heights, Bayview-Hunters Point, Visitation Valley, and Ocean-Merced Heights-Ingleside. (Refer to the Appendix for a map of clients ages 9 to 17 by zip code.)

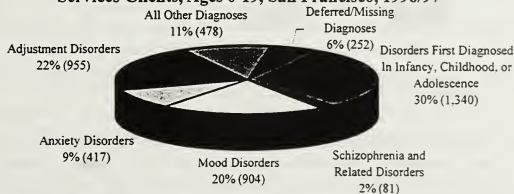
**COMMUNITY MENTAL HEALTH  
SERVICES CLIENTS, AGES 0-19,  
BY ZIP CODE OF RESIDENCE, FY 1996/97**

<u>Zip Code</u>	<u>Neighborhood</u>	<u>#</u>	<u>%</u>
94124	Bayview Hunters Point	496	11%
94110	Mission District	490	11%
94112	Excelsior	357	8%
94134	Visitation Valley	273	6%
94102	Civic Center	159	4%
94115	Fillmore/Western Add'n	150	3%
94122	Inner Sunset	125	3%
94121	Outer Richmond	124	3%
94133	Telegraph Hill	108	2%
-	Other	2,145	49%
94109	TOTAL	4,427	100%

Source: San Francisco Department of Public Health, Community Mental Health Services

*By Primary Diagnoses.* In 1996/97, the most common primary diagnostic group for children and youth clients was disorders "first diagnosed in infancy, childhood, or adolescence," which applied to nearly

**Primary Diagnostic Groups, Community Mental Health  
Services Clients, Ages 0-19, San Francisco, 1996/97**



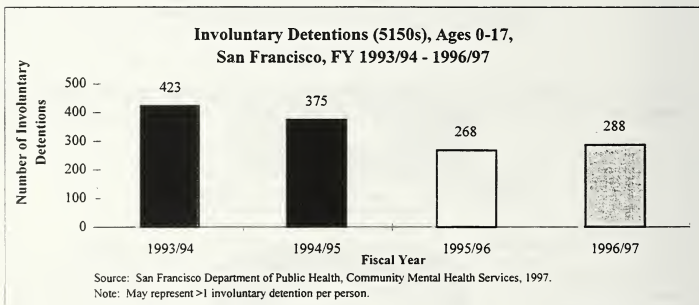
Source: San Francisco Department of Public Health, Community Mental Health Services

one-third (30%) of clients (1,340) at entry into services.<sup>15</sup> Within this diagnostic group, the most common diagnoses were oppositional defiant disorder (507), attention deficit hyperactivity disorder (258), and conduct disorder (258). The second and third most common primary diagnostic groups were adjustment disorders (22%; 955 clients) and mood disorders, including dysthymic disorders and major depression (20%; 904 clients). (Refer to the Appendix for detailed data.)

**Highlights of System of Care Components.** The following sections describe key service components of San Francisco's System of Care for children and youth including the demographic and the most recently available outcome data for these services.

*Crisis Services; Involuntary Detentions (5150s).* In San Francisco, the Comprehensive Child Crisis Service (CCCS) provides 24-hour comprehensive mental health assessment and crisis services for children and youth undergoing mental health crisis. CCCS functions as a gatekeeper into hospital services placing children and youth as necessary in psychiatric hospitals for a 72-hour evaluation period through the 5150 involuntary hospitalization process. Children or youth are admitted on a 5150 to a psychiatric hospital when they are found to be a danger to themselves or others.

In FY 1996/97, CCCS certified the need for 288 involuntary detentions (5150s) among San Francisco children and youth under age 18. This represents a 32% decline in the number of child and youth 5150s compared to FY 1993/94 (423), and contrasts with the 17% rise in 5150s among adults (18+ years of age) during the same time period (from 7,952 to 9,293). CMHS provides services to children and youth under 5150s if they receive Medi-Cal and/or have limited or no resources.



*Psychiatric Inpatient Hospitalizations.* As of early 1998, three facilities provided most psychiatric inpatient hospitalizations for children and youth residents of San Francisco including Ross Hospital (located in Kentfield in Marin County), McAuley Neuro-Psychiatric Institute at St. Mary's Medical Center in (San Francisco) and Walnut Creek Hospital (in Contra Costa County).

<sup>15</sup> Primary diagnoses are categorized within the primary diagnostic groups shown. Primary diagnoses are the first listed DSM IV Axis I diagnoses made at entry into services with the most continuous provider. The episode of care with the provider may have begun prior to the 1996/97 period..

From 1990 through mid-1996, a total of 1,102 child psychiatric hospitalizations occurred at McAuley Neuropsychiatric Institute and Langley Porter Neuropsychiatric Institute Inpatient Services at the University of California, San Francisco, with most hospitalizations (74%) at McAuley. An average of 137 children and youth were hospitalized each year at McAuley, and an average of 42 children and youth per year were hospitalized at Langley Porter.<sup>16</sup> Most (70%) of hospitalized children and youth were hospitalized only once, while others were admitted from two to fifteen times. The number of hospitalizations peaked in 1993 at 185 and declined to 166 in 1995. The average length of stay declined by almost half, from 22.5 days in 1990 to 11.5 days in 1995. As of April 1998, Langley Porter discontinued providing child psychiatric hospitalization.

*State Psychiatric Inpatient Care.* State hospitalization occurs only when providers find it impossible to contain a youth in a local treatment setting. Whenever possible, locales seek to decrease their reliance upon this most restrictive level of psychological service by providing effective and accessible care in the community.<sup>17</sup> Between 1985 and 1995, 38 children and youth from San Francisco were admitted to Napa State Hospital, which had been the state's single psychiatric hospital providing intensive, long-term 24-hour care to Northern California children and youth with severe mental disabilities. Children and youth hospitalized at Napa State suffered from severe episodes of violence, acute uncontrollable suicidality, and/or long standing organic and developmental problems, and represented a danger to themselves and others.

The majority (84%) of these 38 children hospitalized at Napa were admitted only once. The children ranged from ages 7 to 17, with an average age of 13. Two-thirds (26) were male and one-third (12) were female. Nearly half (47%; 16) were African American and 21% (7) were biracial. Others include Caucasian (18%; 6), Asian/Pacific Islander (9%; 3), and Hispanic (6%; 2).<sup>18</sup> On average, children and youth were hospitalized at Napa for 25 months, with a range of 3 weeks to over 7 years. Upon discharge from Napa, patients moved to other similar level of care facilities (16%), to sub-acute residential settings or group homes (26%), to their families (13%), or to other arrangements (35%). In 1998, Napa State Hospital closed its Children's Unit and all State hospitalizations now occur at Metropolitan Hospital in Los Angeles.

*Residential Treatment.* Residential treatment programs are private, non-profit facilities licensed by the State Department of Social Services to provide 24-hour care to children and youth in need of significant structure and comprehensive services in order to progress emotionally, developmentally and behaviorally. The facilities combine residential, educational, and clinical services in one setting. Most San Francisco children and youth are placed in residential treatment programs (out-of-home care) under the auspices of the Juvenile Court, through the San Francisco Department of Human Services or the San Francisco Juvenile Probation Department. Children and youth whose need for residential treatment is educationally based and who are identified through the Special Education Individual Educational Plan (IEP) process as Seriously Emotionally Disturbed are placed by CMHS and San

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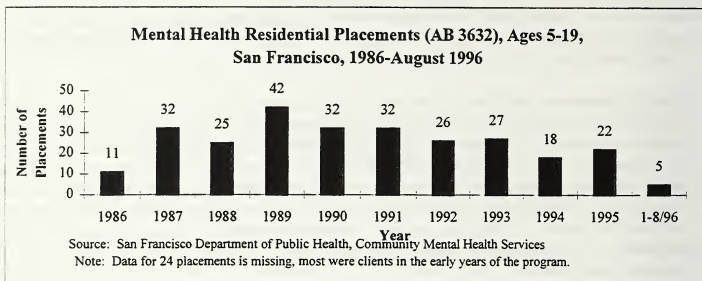
<sup>16</sup> San Francisco Department of Public Health, Community Mental Health Services, Mental Health Funded Child Psychiatric Inpatient Hospitalizations, 1990-Mid-1996, January 1997.

<sup>17</sup> San Francisco Department of Public Health, Division of Mental Health and Substance Abuse Services, System of Care for Children and Youth With Mental Health Needs and Their Families in the City and County of San Francisco, February 1997.

<sup>18</sup> These are the racial/ethnic categories designated by Napa State Hospital.

Francisco Unified School District under provisions of AB 3632.<sup>19</sup> The goal for children placed in residential treatment is to return to the home and/or community as quickly as appropriate.

From the inception of the program in 1986 through August 1996, 190 San Francisco children and youth have been placed in over 40 different mental health residential treatment facilities. The 190



children and youth represented 296 separate placements, an average of 1.6 placements per person. Most clients (122) were placed in care once, while others (68) were placed from two to six times. Over 70% of the placements were made in eleven facilities, four of which are located in San Francisco. The law requires that placements are to be made in the child's home county whenever possible and that other frequently-used facilities are located in adjacent and nearby counties. Over twice as many boys as girls were placed residentially, and the average age at the time of first admission was 13 years (range of ages 5 to 19).<sup>20</sup>

The number of placements has declined since 1989, most likely related to an increase in community support services including the inception of the Family Mosaic Project (in 1989) with its intensive case management and "wrap-around" service capacity.

*Intensive Case Management - Family Mosaic Project.* The Family Mosaic Project (FMP) is an intensive case management program that helps children and youth ages 3 to 18 with severe emotional problems and their families overcome fragmentation of treatment services that can result in expensive, traumatic, and frequent out-of-home placements. From 1990 to mid-1997, FMP served 696 children

<sup>19</sup> AB 3632 refers to a California State Assembly bill, the Special Education Individual Education Plan and Special Education Pupil (SEP) Program, a school-based program that identifies and treats children with mental health problems. Passed in 1985, the law establishes interagency responsibilities for providing services to handicapped children. Local mental health programs are responsible for providing mental health services to youth in SEPs who need treatment, including placement in residential treatment facilities, in order to benefit from their education. If placed out-of-home, the local mental health department is responsible for providing service coordination (case management). Children and youth must be at least school age and up to age 22 to qualify for AB 3632 services. Youth may continue to be eligible for special education, including AB 3632 services, until they receive their high school diploma or attain the age of 22, whichever comes first.

<sup>20</sup> San Francisco Department of Public Health, Community Mental Health Services, Mental Health Funded AB 3632 Residential Treatment, 1986-August 1996, December 1996.

and families with an average participation length of 14 months.<sup>21</sup> In partnership with other public and private child serving agencies, multi-disciplinary, multi-ethnic, and multi-lingual case managers and family advocates of FMP provides a diverse continuum of support services to the children, youth and their families in school, home and neighborhood settings. Services range from mental health treatment, case management, family advocacy, specialized tutoring, mentoring, respite care, and individualized services. The program has demonstrated positive outcomes including reduction in inpatient hospitalizations and out-of-home residential placements; reduction in criminal offenses and detentions; and associated cost-savings due to reduced institutional care and reduced criminal involvement.

From 1991 to 1995, FMP's recidivism rate was almost 20 points below the national average recidivism rate of 70% for juvenile offenders, with an average rate of pre- and post- felony offenses dropping by 46%.<sup>22</sup> In addition, children, youth and families served by FMP experienced:

- More stable and manageable behavior within a wider support network;
- Improved adaptive functioning and coping skills in home, school, and community settings;
- Return to autonomous development with opportunities to plan for a constructive future;
- Strengthened family connections, trust and responsibility;
- Improved peer relations and positive social activities;
- Reduced negative health and mental health outcomes and lifestyle patterns; and
- Reduced criminal victimization.

*SED (Severely Emotionally Disturbed) School Mental Health Partnerships Programs.* Since 1993/94, CMHS and the San Francisco Unified School District have collaborated to support teachers and other special education personnel in 33 Severely Emotionally Disturbed (SED) special day classrooms at the 1<sup>st</sup> through 12<sup>th</sup> grade levels in 20 different schools. In 1996/97, the program served 352 children and youth including 75% male and 25% female enrollees. More than half (54%) were African American, 14% Latino, 9% Asian/Pacific Islander, 4% Caucasian, 2% American Indian, 17% "other" or unknown. Most children and youth in SED classrooms had learning disabilities (50%) or serious emotional disturbances (44%) as their primary handicapping condition. The remaining children and youth had other conditions including mild to moderate cognitive delays, and speech, hearing, or language impairments.<sup>23</sup>

*CASARC.* In 1997, Child and Adolescent Sexual Abuse Resource Center (CASARC) treated 422 children and youth ages 0 to 18 who were victims of sexual abuse, incest, or assault.<sup>24</sup> CASARC operates under the auspices of Community Mental Health Services of the San Francisco Department of Public Health. CASARC provides 24-hour forensic crisis intervention and mental health treatment services to victims of sexual abuse and molestation. Mental health treatment services are critical and essential for children who are emotionally traumatized as a result of sexual abuse.

<sup>21</sup> San Francisco Department of Public Health, Community Mental Health Services, Children, Youth and Family Services Section, Family Mosaic Project-Summary of Outcomes (1990-1997), November 1997.

<sup>22</sup> San Francisco Department of Public Health, Community Mental Health Services Section, Family Mosaic Project, Juvenile Probation Outcome Data: Rates of Offense as A Function of Program Involvement (1991-1995), Preliminary Data, July 1996.

<sup>23</sup> San Francisco Department of Public Health, Community Mental Health Services, School Mental Health Partnerships Teachers Reports on SED Children and Youth, 1996-97 School Year (Preliminary Data), September 1997

<sup>24</sup> Child and Adolescent Sexual Abuse Resource Center, Child and Adolescent Sexual Abuse Resource Center 1997 Statistics, 1998.

In 1997, two-thirds (68%; 286) of CASARC clients were female and nearly all (95%; 245 of 259) perpetrators were male. Clients were from all age groups: ages 0 to 3 (17%; 73 clients), ages 4 to 6 (26%; 109), ages 7 to 10 (22%; 91), ages 11 to 14 (19%; 80), ages 15 to 18 (14%; 58), and unknown ages (3%; 11). Forty-two percent (176) of clients were African American, followed by Latino (23%; 98), Caucasian (17%; 70), Asian/Pacific Islander (8%; 32) and "other" racial/ethnic groups (11%; 46).<sup>25</sup>

*Foster Care Mental Health Program.* The Foster Care Mental Health Program (FCMHP) was created as a collaborative effort between the Children, Youth, and Families Services section and the San Francisco Department of Human Services (DHS) to serve the mental health needs of children and youth from birth to age 18 who have been removed from the family home as a result of abuse, neglect or abandonment or those who are at-risk for out of home placement. This population served by the Children and Family Services of DHS currently consists of approximately 4,200 San Franciscan children and youth.

The FCMHP was developed in response to a need for centralized and systematic access, comprehensive assessments, coordination of mental health services, quality controls and interagency training and collaboration. The program strives to insure that all of these needs are met by overseeing access and authorization of mental health services for foster children. The program reviews mental health screenings completed by Child Welfare Workers, performs child and/or family assessments (or authorizes assessments by designated providers), provides case management that ensures that children connect to referred treatment providers, and authorizes treatment.

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<sup>25</sup> These are the racial/ethnic categories designated by CASARC.

## ORAL HEALTH

Improvement in oral health in the U.S. is one of the major public health success stories of this century. Public health measures such as fluoridation of water, preventive approaches for self-care including brushing with fluoride and flossing, and dental services have resulted in dramatic improvements in oral health status for many children.

Most oral diseases are preventable if families have access to dental care. Untreated dental disease can lead to irreversible damage including disfigurement and nutritional problems, and is more painful, costly, and difficult to treat compared to preventive dental care. Greater use of preventive approaches can reduce further the prevalence of oral diseases and produce improvements in oral health.

Not all children have benefited from preventive dental care. Access to dental services continues to be a problem in San Francisco and throughout the state since dental services are costly and are typically not subsidized. Therefore, families lacking resources for dental services, especially preventive dental care, generally have greater treatment needs.

### Data Sources

Data on the oral health of children and youth in San Francisco are limited. The majority of data for this section were obtained from 2 sources that were available:

- The Oral Health of California's Children-A Neglected Epidemic, by the Dental Health Foundation. The report presents the results of a study based on examinations of 6,792 children in public schools in ten geographic areas of California, representing twelve of the thirteen most populous counties in the state (public schools represent about 90% of California school children in grades K-12). San Francisco was one of three fluoridated urban areas in the survey.<sup>1</sup> However, due to the limited sample size in each area surveyed, county-specific data was not available from the survey.
- A Dental Screening Program called "A Smile For All Seasons" conducted within the San Francisco Unified School District by the San Francisco Department of Public Health during the 1996/97 school year. The program involved 40 San Francisco public schools (33 preschools and 7 elementary schools) with a total of 1,243 preschool and 736 elementary school students participating.<sup>2</sup> Schools participating in the program were selected based on a high proportion of low-income students. Therefore, it is likely that these data represent San Francisco children with greater economic barriers to dental care than may exist among all children in the City.

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<sup>1</sup>The survey targeted three different age groups (preschool, n= 2,649; elementary grades K-3, n=3,234; and high school grades 10-12, n=909), and also targeted fluoridated, unfluoridated, urban, and rural areas of the state.

San Francisco schools included in the survey were:

- Preschools: Community Children's Nursery, Kai Ming Head Start-Clay, Mission Head Start-Regina Chiong, mission Head Start-Valencia, Pacific Primary, San Francisco Health Start-OMI, San Francisco Head Start-Westside, SFUSD-Raphael Weill Nursery, SFUSD-Theresa S. Mahler, Yook Yau Ji Ga Day Care
- Elementary Schools: Buena Vista, Jose Ortega Elementary, Monroe Elementary, Raphael Weill Elementary
- High Schools: J. Eugene McAteer High, Newcomer High, John A. O'Connell High

<sup>2</sup> The program targeted nearly all San Francisco public preschools, and a small proportion of elementary schools with a large proportion of low-income students. The number of San Francisco children included in the survey was not available). There are a total of 39 public preschools in San Francisco, with a total enrollment of approximately 3,000; all public preschools in the City are designated for low-income children. There are 72 public elementary schools in San Francisco, with a total enrollment of approximately 33,000.

## Fluoridation

Community water fluoridation is the single most effective and efficient means of preventing dental caries (cavities) in children and adults, regardless of race or income level.<sup>3</sup> Since 1954, San Francisco has been the only 100% fluoridated city and county in the State.<sup>4</sup> San Francisco has surpassed the Healthy People 2000 objective to increase to at least 75% the proportion of people served by community water systems providing optimal levels of fluoride. In 1993/94, throughout California, children in fluoridated urban areas had less tooth decay than children in non-fluoridated urban and rural areas.<sup>5</sup>

## Early Childhood Caries

Early childhood caries, also known as Baby Bottle Tooth Decay (BBTD), is a form of dental decay experienced by toddlers caused by use of sugary beverages in baby bottles and lack of proper oral hygiene. Early treatment of tooth decay is essential to prevent further destruction and pain. In 1993/94, throughout California:<sup>6</sup>

- 14% of all preschool children had BBTD (one or more teeth affected).
- The prevalence of BBTD was as high as 45% for Asian children in Head Start preschools in non-fluoridated urban regions compared to only 0.4% of white non-Head Start preschool children in fluoridated urban areas.
- Only 68% of parents/guardians used feeding practices that prevent BBTD. This falls short of the Healthy People 2000 objective to increase to at least 75% the proportion of parents and caregivers using feeding practices that prevent baby bottle tooth decay.

## Oral Health Screening, Referral, and Follow-Up

Undiscovered tooth decay in preschoolers can begin a lifetime of tooth destruction and pain. Since dentistry is delivered in a completely separate system, most parents neglect to make a dental examination part of preschool children's care, even if the pediatrician makes a referral.<sup>7</sup>

In 1993/94, in California, almost half (44%) of parents/guardians of preschool children said that their child had never visited a dentist.<sup>8</sup> This is far short of the Healthy People 2000 objective to increase to at least 90% the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow-up of necessary diagnostic, preventive, and treatment services.

## Dental Cavities; Untreated Tooth Decay

Dental cavities (also referred to as "caries") are perhaps the most prevalent disease known. Early diagnosis and timely treatment of dental caries can halt tooth destruction and prevent tooth loss. While

<sup>3</sup> Burt, B.A. "Cost Effectiveness of Caries Prevention in Dental Public Health." *Journal of Public Health Dentistry* 49(5), 1989.

<sup>4</sup> This is possible since the City has only one water system, unlike all other cities and counties in the state, each supplied by more than one water system.

<sup>5</sup> Dental Health Foundation, *The Oral Health of California's Children-A Neglected Epidemic*, by the Dental Health Foundation, San Rafael, California: 1997

<sup>6</sup> Dental Health Foundation, *The Oral Health of California's Children-A Neglected Epidemic*, by the Dental Health Foundation, San Rafael, California: 1997

<sup>7</sup> Dental Health Foundation, *The Oral Health of California's Children-A Neglected Epidemic*, by the Dental Health Foundation, San Rafael, California: 1997

<sup>8</sup> Dental Health Foundation, *The Oral Health of California's Children-A Neglected Epidemic*, by the Dental Health Foundation, San Rafael, California: 1997

the beginning of the loss of the baby teeth around age 6 is a major event in the child's development, it is also a critical time when visits to the dentist to prevent irreversible damage to the permanent teeth should begin.<sup>9</sup> Throughout the U.S., the prevalence of dental cavities (also known as "caries") has been declining steadily since the 1940s, so that only half of school age children in the U.S. have any decay in their permanent teeth.<sup>10</sup>

**Preschoolers.** Among San Francisco public preschools, in 1996/97, 33% (410 of 1,243) of children had treated (filled) and untreated (unfilled) dental caries of which over half (222) had untreated caries.<sup>11</sup> This compares to 31% of preschool children statewide, in 1993/94, who had treated and untreated dental caries. With the exception of African American children, all other ethnic groups of preschool children (Asians, Hispanics, whites) had a lower prevalence of tooth decay in fluoridated areas compared to unfluoridated urban and rural areas.<sup>12</sup>

**Elementary School Students.** Among public elementary school children in San Francisco, two-thirds (66%) had treated or untreated dental caries, of which over half (270) had untreated caries.<sup>13</sup> The prevalence of dental caries in San Francisco is similar to the state (69%), although the proportion of untreated tooth decay in the State, within grades K-3, in 1993/94, was higher (53%).<sup>14</sup>

Both San Francisco and California fall short of achieving the Healthy People 2000 objective of reducing the proportion of children ages 6 to 8 with one or more caries to no more than 35% and reducing untreated dental caries in permanent or primary teeth among children ages 6 through 8 to no more than 20%.<sup>15</sup>

**10th Graders.** Among 10th graders in California, in 1993/94, three-fourths (78%) had some tooth decays (data for San Francisco not available). African American 10th graders in fluoridated urban areas had the lowest proportion of untreated or treated tooth decay (58%), and white students in fluoridated urban areas had the lowest average number of teeth affected (2.3). Healthy People 2000 seeks to reduce the proportion of adolescents age 15 (comparable to 10th graders) with one or more caries to no more than 60%, and the proportion of untreated caries to no more than 15%.<sup>16</sup>

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<sup>9</sup> National Institute of Dental Research. Oral Health of United States Children. The National Survey of Dental Caries in U.S. School Children 1986-1987. DHHS Publications No. (NIH) 89-2247 Bethesda, MD: U.S. Department of Health and Human Services, 1989.

<sup>10</sup> National Institute of Dental Research. Oral Health of United States Children. The National Survey of Dental Caries in U.S. School Children. 1986-1987. DHHS Publication No. (NIH) 89-2247. Bethesda, MD: U.S. Department of Health and Human Services, 1989

<sup>11</sup> San Francisco Department of Public Health, Dental Programs, 1996/97 Dental Screening Program Results

<sup>12</sup> Dental Health Foundation, The Oral Health of California's Children-A Neglected Epidemic, by the Dental Health Foundation, San Rafael, California: 1997. There are no Healthy People 2000 objectives specifically targeting the preschool population.

<sup>13</sup> San Francisco Department of Public Health, Dental Programs

<sup>14</sup> Dental Health Foundation, The Oral Health of California's Children-A Neglected Epidemic, by the Dental Health Foundation, San Rafael, California: 1997

<sup>15</sup> U.S. baseline (1986/87) of children ages 6 to 8 with treated or untreated caries was 53% of children. Healthy People 2000 13.1 sub-objectives refer to reducing caries among additional sub-populations of children ages 6 to 8 including children whose parents have less than high school education, American Indian/Alaska Native children, and black children.

<sup>16</sup> U.S. baseline (1986/87) was 78% of adolescents age 15. Healthy People 2000 objective 13.1 also refers to reducing caries among American Indian/Alaska Native adolescents age 15.

## Sealants

Sealants are plastic coatings that are applied to the chewing surfaces of molar teeth, and have existed since early 1970's. If sealants were applied, experts estimate that most tooth decay (up to 90%) among American children could be prevented. Sealants are applied permanently after molars appear, when children are approximately 6 to 8 years old and again when they are 12 to 14 years old. When applied properly, sealants are exceptionally safe, highly effective, and long lasting.

In California, in 1993/94:<sup>17</sup>

- Only 8% of 8-year old children have received protective sealants on the chewing (occlusal) surface of at least one of the four permanent first molar teeth.
- While 33% of white high school students in fluoridated urban areas had a sealant, no Asian students and 6% of Hispanic students in fluoridated urban areas had a sealant.

In San Francisco, in 1996/97:<sup>18</sup>

- Only 6% of children ages 6 to 10 in San Francisco attending public Schools (with a high proportion of low-income students) had protective sealants.

In California, in 1994/95:<sup>19</sup>

- Less than 1% of children in Medi-Cal received sealants. (This is the time period that Medi-Cal began routinely reimbursing for sealants.)

The prevalence of sealants in school-age children falls greatly below the Healthy People 2000 objective to increase to at least 50% the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.

## Dental Insurance Coverage

In California, in 1993/94, about one-quarter (26%) of California's preschool children had no dental insurance and 21% depended on Medi-Cal (Denti-Cal) for their dental care.<sup>20</sup> (Also refer to the Medi-Cal section in this report.)

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<sup>17</sup> Dental Health Foundation, The Oral Health of California's Children-A Neglected Epidemic, by the Dental Health Foundation, San Rafael, California: 1997

<sup>18</sup> San Francisco Department of Public Health, Dental Program, 1996/97 Dental Screening Program data

<sup>19</sup> California Department of Health Services, Medi-Cal Program

<sup>20</sup> Dental Health Foundation, The Oral Health of California's Children-A Neglected Epidemic, by the Dental Health Foundation, San Rafael, California: 1997

## CHILD ABUSE AND NEGLECT

Children who are maltreated often experience disrupted growth and development, including adverse effects on their physical, cognitive, emotional, and social development. For some children, maltreatment may be fatal. Psychological problems are common among children who have been maltreated. Physically abused children tend to be aggressive towards others and are less able to be empathetic towards others. Young children who are maltreated may fail to develop the social skills needed to form healthy relationships with peers and adults. As they get older, children who have been abused and neglected are more likely to perform poorly in school and to commit crimes against persons. They more often experience emotional problems, depression, suicidal thoughts, sexual problems, and alcohol/drug abuse.<sup>1</sup> However, for any given child, the consequences of abuse and neglect will depend on the intensity, duration, and type of abuse; the presence of supportive adults; and the age of the child at the time of the abuse.

Risk factors for child abuse and neglect include alcohol/drug abuse, psychological impairment, and a history of child abuse or domestic violence in parents or caregivers. Although child abuse and neglect occur in families of all income brackets, cases of child maltreatment occur disproportionately among lower-income families.<sup>2</sup> While most poor people do not mistreat their children, the stress and frustration of living in poverty combined with other risk factors such as lack of parenting skills, depression, social isolation, drug/alcohol abuse, and exposure to violence increase the likelihood of maltreatment.

Younger children, girls, and premature infants are more vulnerable to abuse and neglect. Other than sexual abuse, which occurs more frequently among girls, other types of maltreatment affect both sexes about equally.<sup>3</sup> In addition, it should be noted that accusations against the families of poor children, especially those with infants and young children, are more likely to be pursued than cases against children in wealthier families and neighborhoods.<sup>4</sup>

### Data Source

The exact number of children who were abused or neglected is unknown, since these incidents may or may not have been reported to child protective services agencies that are charged with collecting and responding to reports of child maltreatment.<sup>5</sup> In the absence of prevalence data on child abuse and neglect, this section of the report presents data on children whose abuse or neglect was reported to local child protective service agencies, the San Francisco Department of Human Services in San Francisco, in order to provide some indication of the extent and patterns of child abuse and neglect in the City.

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<sup>1</sup> Starr, R.J., Jr., MacLean, D.J., and Keating, E.P. "Life-Span Developmental Outcomes of Child Maltreatment." In The Effects of Child Abuse and Neglect: Issues and Research, R.H. Starr, Jr., and D.A. Wolfe, eds. New York: The Guilford Press, 1991; Sedney, M.A., and Brooks, B. "Factors Associated With a History of Childhood Sexual Experience in a Nonclinical Female Population," Journal of American Academy of Child Psychiatry, 12, 1: 215-218, 1984

<sup>2</sup> Gelles, R.J. "Poverty and Violence Toward Children," American Behavioral Scientist, 35, 3:258-74, 1992

<sup>3</sup> Sedlak, A.J., and Broadhurst, D.D. The Third National Incidence Study of Child Abuse and Neglect. D.C.: U.S. Department of Health and Human Services, 1996

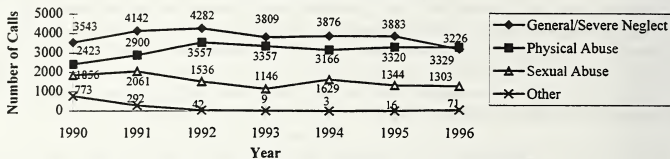
<sup>4</sup> Pelton, L.H. "The Role of Material Factors in Child Abuse and Neglect." In Protecting Children From Abuse and Neglect: Foundations for a New National Strategy. G.B. Melton and F.D. Barry, eds. New York: Guilford Press, 1994.

<sup>5</sup> National Research Council. Understanding Child Abuse and Neglect. D.C.: National Academy Press, 1993

## Emergency Response Calls

In 1996, the San Francisco Department of Human Services (SFDHS) Emergency Response system received 7,929 calls, or an average of 22 calls per day, reporting possible abuse, neglect, exploitation, or abandonment of children and youth in San Francisco.<sup>6</sup> The number of calls decreased by 7% since

**Emergency Response System Calls, By Reason For Call,  
San Francisco, 1990-1996**



Source: Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center

1990, compared to a 28% increase statewide. Most calls in 1996 were for physical abuse (42%) or general neglect (41%). Sixteen percent were for sexual abuse and 1% were for “other” reasons such as exploitation, child’s disability or handicap, relinquishment, disrupted adopted placement, and voluntary placement. These proportions were similar to those for the state as a whole.<sup>7</sup>

## Removal From Home

Under supervision of the juvenile court, children and youth up to 18 years of age are removed from the home and placed in foster care with a relative, foster or group home when it is determined that they cannot safely remain at home due to abuse or neglect or that leaving the child or youth at home poses a continued risk. The San Francisco Department of Human Services is the public agency responsible for children in foster care.<sup>8</sup> Foster care is defined as out-of-home placement for a child under the supervision of the juvenile court and does not include children under the supervision of probation or other agencies.

From 1996 to 1997, the number of children who were removed from the home for the first time into emergency shelters dropped 15% (from 591 to 504). This decrease in the number of first time emergency shelter placements was attributed, at least in part, to the agency’s recent increased efforts to preserve families by keeping children with their families or with relatives willing to care for them.<sup>9</sup>

<sup>6</sup> The Emergency Response system is also referred to as the San Francisco Child Abuse Hotline. Reports to the system may include multiple reports per child.

<sup>7</sup> Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center

<sup>8</sup> The Family and Children’s Services (FCS) Division of the San Francisco Department of Human Services is the local public agency responsible for protecting children when a threat of abuse or neglect, presents a danger to the child’s safety. Every child under age 18 in San Francisco may potentially utilize the services of FCS.

<sup>9</sup> San Francisco Department of Human Services, Child Protection Center, Emergency Shelter Care Annual Report 1997

In San Francisco, children and youth can also be placed out-of-home by public institutions through two additional mechanisms:

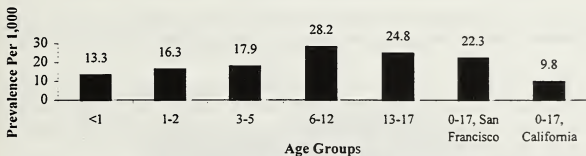
- **Juvenile Probation Placement:** When the child or youth has committed a crime, San Francisco Juvenile Probation may place the child in a group home for rehabilitation and for the safety of others. (Data on Juvenile Probation placements is not covered in this report.)
- **AB 3632 Special Education Placement:** When the child or youth is seriously emotionally disturbed (SED) and requires out-of-home placement, the parent(s), San Francisco Unified School District, and Community Mental Health Services (within the San Francisco Department of Public Health) jointly determine the need for placement. CMHS then places the child in an appropriate group home or therapeutic foster home setting. (Refer to the "Mental Health" section of this report for a review of children and youth in AB 3632 placement.)

From January to mid-September 1998, SFDPH filed a total of 301 petitions with the court to consider removing the child from the home compared to 951 petitions filed in 1995. The significant decline in the number of petitions filed is considered to be an indication of the agency's recent efforts to preserve families and prevent or avoid removal whenever possible.

### Foster Care

In 1996, there were 3,058 San Francisco children and youth ages 0 to 17 in foster care.<sup>10</sup> San Francisco's rate of foster care placement, 22.3 per 1,000 population, is the highest rate per capita in the

**Children and Youth In Foster Care, Prevalence Per 1,000,  
Ages 0-17, By Age Groups, San Francisco and California, 1996**



Source: Source: Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center

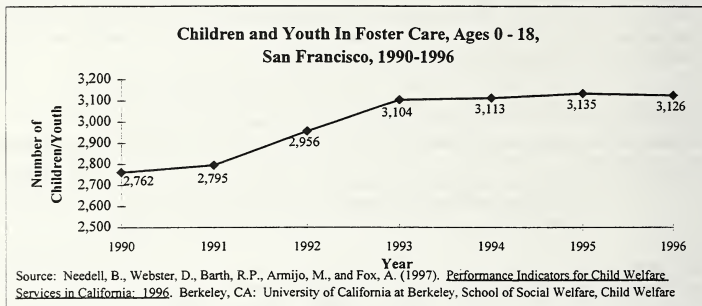
state, and significantly higher than the statewide rate of 9.6.<sup>11</sup> San Francisco's rate is high, in part, because about 50% of children needing foster care are placed with relatives who often need the financial support available as a result of designating the child with foster care status. San Francisco's

<sup>10</sup> These only include children and youth placed out-of-home in foster care under the San Francisco Department of Human Services. These do not include children in out-of-home placement under Juvenile Probation or AB 3632 Special Education as described in the section above. Note that these are the number of children and youth ages 0 to 17 in foster care. Data throughout most of this section of the report refers to children and youth ages 0 to 18 in foster care.

<sup>11</sup> Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare. Child Welfare Research Center. Alpine (22.1) and Los Angeles (16.2) counties were second and third ranking in the state.

high cost of living makes it more critical for caregivers of children needing foster care to receive adequate financial support to raise the children. The only other option for financial support for a relative caregiver is Temporary Assistance to Needy Families (TANF), which provides a lower payment amount to relative caregivers compared to non-relative caregivers of foster care children. (State legislation has recently been introduced to increase the level of TANF payments to relative caregivers to the same level as non-relative caregivers.) In addition, the foster care system provides support services for children with special needs that are not available to non-foster children, which may serve as an incentive to some caregivers. Providing the same level of TANF payments to relative and non-relative caregivers would allow for the dismissal of many San Francisco foster care cases.<sup>12</sup>

The number of San Francisco children and youth ages 0 to 18 in foster care increased dramatically between 1991 and 1993 (from 2,795 to 3,104), but remained relatively stable from 1993 through 1996.



**Placement Type.** In 1996, nearly all San Francisco children and youth in foster care resided in foster homes or foster family agencies (49%), or were placed with relatives (45%). The remaining children and youth (7%) were in group homes or other settings. These proportions by placement type are similar to statewide patterns.<sup>13</sup>

**Reasons for Removal.** In FY 1996/97, 84% of children and youth from San Francisco in foster care (2,684) had been removed from home because of neglect. Eight percent (251) were removed due to physical abuse, 4% (126) because of sexual abuse, and 4% for other reasons.<sup>14</sup> In 1996, nearly equal numbers of male and female children were removed from the home. However, a greater proportion

<sup>12</sup> San Francisco Department of Human Services, Family and Children's Services Division

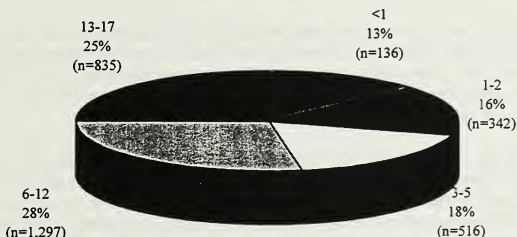
<sup>13</sup> "Foster homes" are placements with nonrelative nonguardians or nonrelative guardians. "Foster family agency homes" are licensed agencies. Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). *Performance Indicators for Child Welfare Services in California: 1996*. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center.

<sup>14</sup> "Other" includes exploitation, child's disability or handicap, relinquishment, disrupted adopted placement, and voluntary placement. State of California Health and Welfare Agency, Department of Social Services, Foster Care Information System.

(74%) of sexual abuse cases involved female children, and a greater proportion of cases of status offense violations (73%) involved male children.

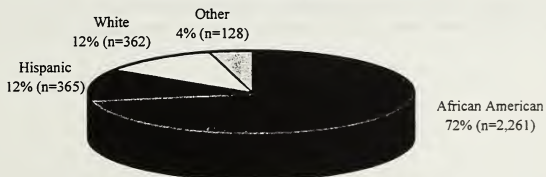
**By Age.** In 1996, more than half (53%) of San Francisco's children and youth in foster care were age 6 or older, about one third (30%) were birth to 2 years of age and 18% were ages 3 to 5.

**Children and Youth In Foster Care, By Age Groups (0-18),  
San Francisco, 1996**



Source: Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center

**Children and Youth In Foster Care, Ages 0 - 18,  
By Race/Ethnicity, San Francisco, 1996**



Source: Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center

**By Race/Ethnicity.** In 1996, almost three-fourths (72%) of San Francisco children and youth in foster care were African American. White and Hispanic children and youth each represented 12% of those in

foster care. Children and youth of “other” race/ethnicities comprised 4% of the foster care population.<sup>15</sup>

Out of County Foster Care. When foster care within the county cannot be found, children and youth are placed in foster care outside of the county. In 1997, nearly half (46%, 1,487) of San Francisco’s children and youth in foster care resided out-of-county, a large percentage compared to many California counties. Most of these children and youth placed out-of-county were in foster homes (50%) or with relatives (40%), compared to in-county placements which were most commonly with relatives (48%), or in foster homes (36%)<sup>16</sup>

San Francisco’s out-of-county placements are high due to an inadequate number of licensed foster care providers in the City, particularly in communities of color. Generally, many foster care providers and relative caregivers reside out of-county due to San Francisco’s high housing costs. The San Francisco Department of Human Services policy is to limit out-of-county placements to no more than 30 miles, which is less distance than many counties have within their boundaries.

Case Plan Goal. In FY 1996/97, the “case plan goal” was to return 38% of San Francisco’s children and youth in foster care to their parents or guardians. The goals for other children and youth in foster care who could not safely return to their parents and were unlikely ever to return home included long term foster care with relatives or non-relatives (38%), legal guardianship (17%), adoption (7%), and other (1% including independent living).<sup>17</sup> Returning foster care children to parents or guardians was a more common goal among children ages birth to 5 (61%), while the more common goal for children and youth ages 6 and older was long-term foster care or guardianship.<sup>18</sup> From 1996 to 1998, there was a substantial increase in the number of children who reunified with their parents, from only 12 in 1996, 80 in 1997, and 328 January through August 1998.<sup>19</sup> This increase in reunifications is considered to be an indication of the agency’s recent, more concerted efforts towards family preservation.

Case Closures: Length of Stay: Recidivism. Among children whose cases were closed in FY 1996/97, two-thirds (63%) were reunited with their family, and 7% were adopted. Nearly one-third (30%) of

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<sup>15</sup> Needell, B., Webster, D., Barth, R.P., Armijo, M., and Fox, A. (1997). Performance Indicators for Child Welfare Services in California: 1996. Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center.

<sup>16</sup> State of California Health and Welfare Agency, Department of Social Services, Foster Care Information System, Ad Hoc Report, May 5, 1997

<sup>17</sup> Regulations require that permanency plans be developed within a hierarchy of choices for foster children for whom family unification will not be possible: adoption, legal guardianship, and long term placement.

<sup>18</sup> State of California Health and Welfare Agency, Department of Social Services, Foster Care Information System, Characteristics of Children By Case Plan Goal, Average Monthly for Trial Year Ended June 1997.

<sup>19</sup> State of California Health and Welfare Agency, Department of Social Services Foster Care Information System. Note: Reunification may not necessarily result in immediate case closure.

cases were closed for "other" reasons such as emancipation, legal and guardianship, inter-county transfers, and foster child who violates the law and is assigned to the Juvenile Probation Department.<sup>20</sup> For the quarter ending December 1995, the average time in foster care for 115 children who were successfully reunified (and whose cases were closed) was 18.4 months.<sup>21</sup>

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<sup>20</sup> State of California Health and Welfare Agency, Department of Social Services, Foster Care Information System, Characteristics of Children in Foster Care Status as of End of Three Consecutive Years (June 1995-1997)

<sup>21</sup> San Francisco Department of Social Services, Family and Children's Services, Annual Statistical Report, January 1, 1995 Through December 31, 1995 (more recent data was not available)

## HOMELESSNESS

According to national estimates, families with children are the fastest growing segment of the homeless population.<sup>1</sup> Nationwide, there are varying estimates on the number of homeless youth (defined as individuals under the age of eighteen who lack parental, foster, or institutional care). The principal causes of homelessness among families are poverty among families and children and the shrinking supply of affordable housing. In addition, domestic violence contributes to homelessness among families.<sup>2</sup> Many homeless youth leave home after years of physical and sexual abuse, strained relationships, chemical addiction of a family members, and parental neglect. Some youth may become homeless when their families suffer from financial crisis involving lack of affordable housing, lack of employment, and separation from families due to shelter policies. In addition, youth who have been in foster care are more likely to become homeless at an earlier age and remain homeless for a longer period of time.

Homelessness is a devastating experience for families with children, disrupting virtually every aspect of family life. Homelessness severely impacts the physical and mental health of homeless children and their caregivers. Compared with housed poor children, homeless children experience worse health; more developmental delays; more anxiety, depression, and behavioral problems; and lower educational achievement.<sup>3</sup> In addition, homeless children face barriers to enrolling and attending school, including transportation problems, residency requirements, inability to obtain previous school records, and lack of clothing and school supplies. Parents of homeless families also suffer from higher rates of depressive disorders and chronic health conditions.<sup>4</sup> Homelessness frequently breaks up families as a result of restrictive shelter policies or because parents leave their children with relatives and friends to avoid having them be homeless.

Homeless youth face many challenges on the streets. Because of their age, homeless youth have few legal means by which they can earn enough money to meet basic needs. Many homeless adolescents find that exchanging sex for food, clothing, and shelter is their only chance of survival on the streets. In turn, homeless youth are at great risk of contracting AIDS or HIV-related illnesses. Homeless adolescents often suffer from severe anxiety and depression, poor health and nutrition, and low self-esteem. They have difficulties attending school and completing their education, which reduces their chances of supporting themselves both financially and emotionally.<sup>5</sup>

### Data Sources

In the absence of accurate counts of the number of homeless children in families or the number of homeless youth in the City, this section will provide data from two major programs in the City which

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<sup>1</sup> Shinn, Marybeth and Beth Weitzman. "Homeless Families Are Different." In Homelessness in America, D.C.: National Coalition for the Homeless, 1996

<sup>2</sup> Homeless Families With Children (National Coalition for the Homeless Fact Sheet #7, obtained on-line, July 15, 1998, <http://nch.ari.net/families.html>

<sup>3</sup> Shinn, Marybeth and Beth Weitzman. "Homeless Families Are Different." In Homelessness in America, D.C.: National Coalition for the Homeless, 1996. State or county level estimates not available.

<sup>4</sup> Bassuk, et.al. "The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers," Journal of the American Medical Association, 276 (August 28, 1996) 8: 640;646; Homeless Families With Children (National Coalition for the Homeless Fact Sheet #7, obtained on-line, July 15, 1998, <http://nch.ari.net/families.html>

<sup>5</sup> Homeless Youth. Fact Sheet #11, obtained on-line, July 15, 1998, <http://nch.ari.net/youth.html>

were designed to serve families who are homeless or at-risk for homelessness. Data from these programs include information about the families' demographics and some of the social issues affecting families utilizing these services. The two programs covered in this section are:

- Connecting Point (The Family Housing Crisis Center), the City's designated centralized intake into family shelters; and
- The San Francisco Department of Human Services's family shelter programs, specifically information about four of the largest family shelters. (Data on all operating family shelters, public and private, was not available.)

### Connecting Point Program

Connecting Point (The Family Housing Crisis Center) was established in August 1995 to assist families in San Francisco who are homeless or in danger of becoming homeless. The Center is funded by the San Francisco Department of Human Services and the U.S. Department of Housing and Urban Development and serves as the City's designated centralized intake into all available public and private family shelters in the City. The program also provides other services such as crisis counseling, eviction prevention counseling, free food and clothing, and referrals to health and social services.

In 1996/97, Connecting Point's Housing Crisis Hotline received calls from 902 families, a slight increase compared to its first year of operation in 1995/96. There were 1,552 children in these families, half of whom (777) were age 5 or younger.

Connecting Point Housing Crisis Hotline, Location of Families Who Called, 1995/96 and 1996/97				
Location	1995/96		1996/97	
	#	%	#	%
Family/Friends	341	39%	330	37%
Rented Dwelling	67	8%	182	20%
Hotel/SRO	105	12%	102	11%
Streets/Cars	222	25%	67	7%
Shelter	79	9%	49	5%
Residential Treatment	10	1%	13	1%
Other/Unknown	49	6%	159	18%
Total	873	100%	902	100%
Source: Connecting Point Program, <u>Client Telephone Intake Statistics, 1995/96 and 1996/97</u>				

In 1996/97, families who called the Hotline were most often (37%) staying with family or friends, 20% were in rented dwellings, and 17% were in hotels or SROs. The number of calls to the Hotline from families who were living in rental dwellings nearly tripled from the first to the second year of the program, while the number of calls from families staying in cars and in the streets declined

substantially. (Information from Connecting Point on the reasons for these changes in the pattern of calls was not available.)

Most of the homeless families seeking assistance were headed by women (89%; 806). Over half (56%; 502) of the primary caregivers were African American, followed by Latinos (16%; 141), and White (15%; 140). The race/ethnic composition of the children and youth within families was similar to the race/ethnicity of primary caregivers.

<b>Connecting Point Housing Crisis Hotline, Race/Ethnicity of Children in Families Who Called, 1995/96 and 1996/97</b>				
<u>Race/Ethnicity</u>	1995/96		1996/97	
	#	%	#	%
African American	774	53%	837	54%
Latino	258	18%	225	14%
Multi-Racial	119	8%	211	14%
White	194	13%	155	10%
Asian/Pacific Islander	82	6%	64	4%
Native American	23	2%	16	1%
Other/Unknown	16	1%	44	3%
Total	1,466	100%	1,552	100%
Source: Connecting Point Program, <u>Client Telephone Intake Statistics, 1995/96 and 1996/97</u>				

About one in six persons seeking assistance (16%; 164) disclosed domestic violence in the household, and one-third (32%; 288) reported having previously been homeless.

### **Family Shelters**

After the completing the intake process with Connecting Point, some families are placed in family shelters located throughout the City. Over a two-year period, from July 1995 to June 1997, over 676 families (unduplicated count) were housed in and subsequently exited from at least one of the City's four largest family shelters. Three of these shelters were Compass, Hamilton, and Raphael family shelters. An additional shelter, Richmond Hills, operated until June 1996, when it was transferred to St. Joseph. These four shelters have a combined capacity for 211 beds, which represents 72% of all public and private family shelter beds available in the City.

There were a total of 967 children within these families, or an average of 1.4 children per family. Over half (57%; 555) of children in the shelters were age 5 or younger, with an average age of 6. Three-fourths (74%) of primary caregivers were single and 15% were married.

The educational level of primary caregivers was 39% (262) had not graduated high school, 26% (174) had a high school degree or a GED, 28% (193) had college degrees or some college, and 7% had other or unknown educational backgrounds. Most (74%) primary caregiver had as their source of income AFDC (501), or Food Stamps (58%; 393), and 10% (68) had SSI. Seven percent (48) of primary caregivers were employed.

Almost half (47%; 319) of primary caregivers in family shelters were African American, followed by 26% White (177), and 13% Latino (90). Asian/Pacific Islanders, multi-racial, Native American, and other racial/ethnic groups each represented less than 5% of primary caregivers.

Two-thirds of families (68%) were living in San Francisco (381), Alameda (56), or San Mateo (22) counties before entering the shelter. Among families from San Francisco, over half (54%) were from three neighborhoods in the City, including the Tenderloin (74), Bayview Hunters Point (61), and the Mission (55). (Refer to Appendix for more detailed data.)

The three most common causes of homelessness as identified by the families were being asked to move out (24%; 197 families), substance abuse (14%; 116), and dangerous living environment (12%; 98).

**Families in San Francisco Family Shelters,\*  
Self-Identified Causes of Homelessness,  
July 1995 - June 1997**

<u>Cause of Homelessness</u>	<u>#</u>	<u>%</u>
Asked to Move Out	197	24%
Substance Abuse	116	14%
Dangerous Living Environment	98	12%
Domestic Violence	83	10%
Mental Illness	48	6%
Legal Eviction	43	5%
Loss of Job	39	5%
Divorce/Separation	28	3%
Other	176	21%
Total	828	100%

\*Note: Includes Compass, Hamilton, and Rafael family shelters; Richmond Hills through June 1996 and St. Joseph beginning July 1997.  
Source: San Francisco Department of Human Services, Family Survey Statistics, 7/1/95 to 6/30/97

Other causes of homelessness included domestic violence, mental illness, legal eviction, loss of job, divorce/separation, and "other" reasons.

Families in the shelters had been homeless an average of 2.1 times. One in five (20%; 135) primary caregivers had a history of psychiatric hospitalization or residential psychiatric care. Half (50%) of primary caregivers had a history of substance abuse. One-third (34%) of families (227) were involved with the local child protective services agency (San Francisco Department of Human Services).

## CRIME

In San Francisco, the problems of increasing youth violence, drug abuse, and youth gangs have challenged the juvenile justice system.

### Data Source

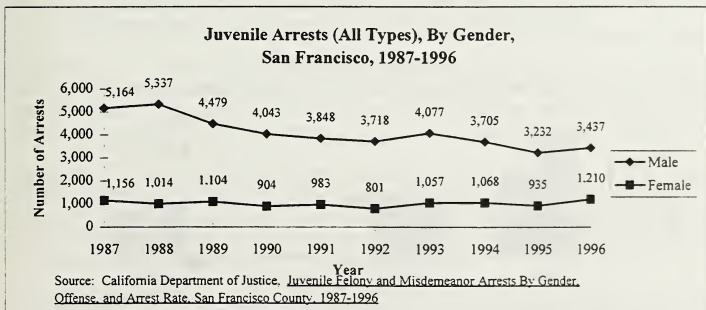
This section of the report presents data mainly on juvenile arrests among children and youth up to age 17. The criminal justice system classifies arrests of individuals 18 years of age and older to be adult arrests, and data segregating young adults from all other adults is not available. It should be noted that in any community, arrest rates reflect policy initiatives, political considerations, police staffing, programmatic changes, and other factors in addition to the actual amount of crime occurring. Arrests do not always result in formal charges, and not all formal charges are sustained (approved or affirmed) in the Juvenile Courts. However, data on arrests is the most readily available, ongoing indicator of the level of crime in communities.

Data for this section was obtained from two sources:

- The California Department of Justice (DOJ) provided county and statewide arrest data, including ten-year trends since 1987. Note that DOJ (and other criminal justice agencies) report only the number of arrests, not the number of unduplicated persons arrested, as a result, one youth can account for more than one arrest.
- The San Francisco Comprehensive Juvenile Justice Action Plan, March 1997 provided data on the patterns of arrests at the neighborhood level, and information on gang activity.

### Juvenile Arrests in San Francisco

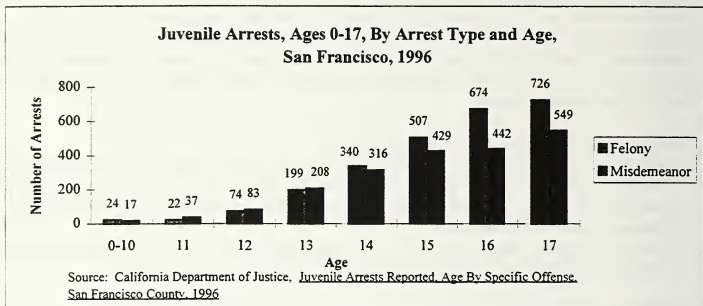
In 1996, there were 4,647 juvenile arrests in San Francisco, representing 8% of all arrests in the City. While this may be high, the number of juvenile arrests declined by 26% from 1987 to 1996, which is



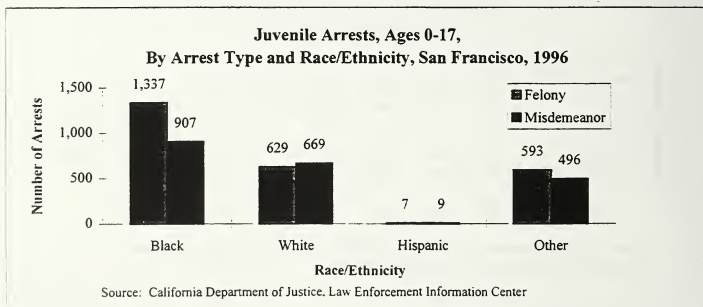
similar to the statewide decrease in juvenile arrests. Males represented three-fourths (74%; 3,437) of juvenile arrests in 1996. Throughout the ten-year period, there were two to five times more arrests

among males than females depending upon the offense. As noted above, arrests represent events rather than people. In fact, some individuals are arrested multiple times, which may help give the impression of overrepresentation of some groups. According to some experts in the field, about 8% of the youth in the juvenile justice system account for the majority of referrals from the Police Department to the Juvenile Probation Department.

**By Age.** The number of arrests among juveniles increases with age, for both felony and misdemeanor categories. In 1996, arrests among youth ages 15 to 17 represented nearly three-fourths (71%) of all juvenile arrests.



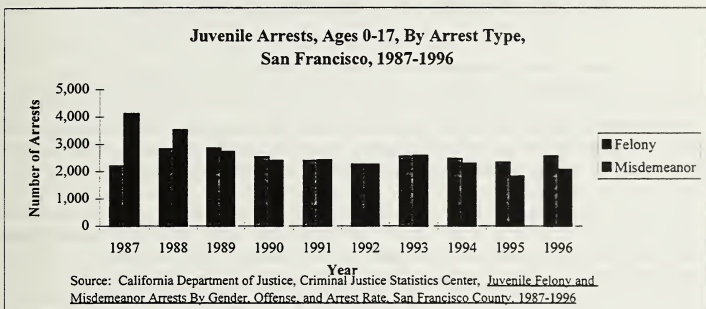
**By Race/Ethnicity.** African Americans comprise a disproportionately large share of juvenile arrests in the City compared to their representation in the City's youth population. In 1996, African Americans accounted for 48% (2,244) of juvenile arrests in San Francisco. White juveniles had the second



largest number of arrests (1,298).<sup>1</sup> The third largest number of arrests were among juveniles of “Other” race/ethnicities which includes Asians, with few arrests among Hispanic juveniles, according to Police Department data. As noted earlier in this section, arrests represent events rather than people.

**By Time of Day.** Analysis of crime patterns reveals that youths ages 10 to 17 are most likely to be involved in crimes in the daytime immediately after school between 3 p.m. and 4 p.m. when youth are out of school but before their parents come home from work. In addition, there is more crime during school hours (noon to 2 p.m.) when youth may be leaving school, compared to the later evening hours (9 p.m. to midnight). During the noon to 2 p.m. hours, youth are likely to be both perpetrators and victims of crime.<sup>2</sup>

**By Arrest Type.** Arrests are classified as felonies or misdemeanors, with the level of punishment reflecting the severity of the offense. A felony is a crime that is punishable with death or by imprisonment in a state prison. A misdemeanor is a crime punishable by imprisonment in a county jail



for up to one year. In 1996, felony arrests in San Francisco among juveniles accounted for over half (55%; 2,566) of all juvenile arrests. In 1996, both felony (2,566) and misdemeanor (1,081) arrests among juveniles increased slightly after two consecutive years of decline. In the past ten years, felony arrests (2,852) peaked in 1989 and misdemeanors (4,115) were at their highest level in 1987.

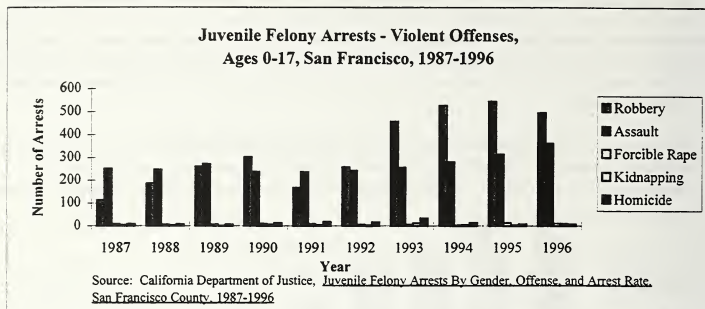
**Violent Crimes.** The sub-categories of felony arrest include violent, property, drug, sex, and “other” offenses. Violent felony offenses are crimes against people, and include homicide, rape, robbery (stealing by force or threat of violence), aggravated assault, and kidnapping. Arrests for violent crimes are a preferred crime indicator because arrests for violent crimes are less likely to be affected over time by changes in police practice and policy than other types of crime.<sup>3</sup>

<sup>1</sup> Race/ethnicity categories are shown as reported by the California Department of Justice, e.g., Asians categorized within “Other.”

<sup>2</sup> Silbert, Mimi H., Delancey Street Foundation, [San Francisco Comprehensive Juvenile Justice Action Plan](#), March 1997 (for the Mayor’s Criminal Justice Council and the California Board of Corrections)

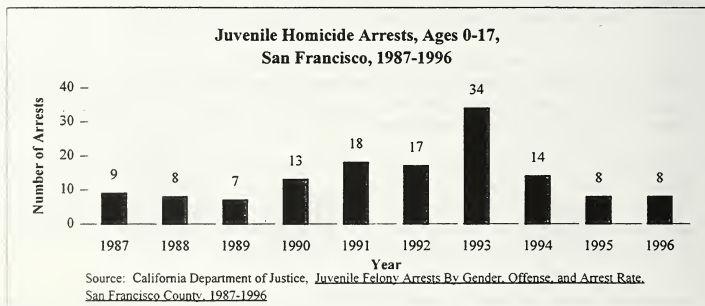
<sup>3</sup> U.S. Department of Health and Human Services, [Trends in the Well-Being of America’s Children and Youth, 1996](#)

In 1996, violent felony arrests among juveniles (887), increased to their highest level within the past ten years, and represented the fifth consecutive year of increase since 1991 (435). The majority of juvenile felony arrests in San Francisco are for robbery and assault. The number of robbery arrests



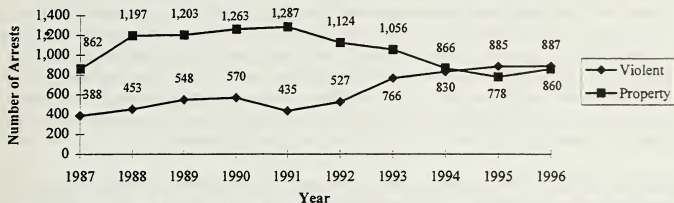
doubled between 1987 to 1996 (from 260 to 496). However, the number of robbery arrests in 1996 decreased to 496, after rising the four prior years. Arrests for assaults increased by 44% from 1987 to 1996 (from 252 to 362). (Refer to the Appendix for more detailed data.)

Of particular concern among violent crimes are homicides, due to the severe nature of the offense. In San Francisco, the number of juvenile arrests for homicide has declined substantially since its peak in 1993 (34 arrests), and by 1996, had returned to pre-1990 levels (8 arrests per year).



**Violent and Property Felony Arrest Trends.** Within the felony category, property offenses are arrests for crimes against property, including burglary, motor vehicle theft, forgery and check offenses, and

### Juvenile Violent and Property Offenses (Felony) Arrests, Ages 0-17, San Francisco, 1987-1996



Source: California Department of Justice, *Juvenile Felony Arrests By Gender, Offense, and Arrest Rate, San Francisco County, 1987-1996*

arson. Property arrests among juveniles have declined by one-third since 1991. This is in contrast to the number of violent felony arrests, which has more than doubled since 1991.

**Arrests By Neighborhood.** Juvenile crime in San Francisco is concentrated in a few census tracts. In general, specific neighborhoods either have little crime or a high incidence of crime and crimes tend to be concentrated in low-income areas of the City. The Mission has the highest volume of crime, followed by Bayview Hunters Point, the Western Addition, and the Tenderloin.<sup>4</sup> (Refer to three maps in the Appendix including “Crimes Involving Juveniles, 1996,” “Crimes with Juvenile Involvement per 1,000 population, 1996,” and “Persistent Youth Crime Hot Spots In San Francisco: 1993-1996.”)

### Youth Gangs

In 1997, the San Francisco Police Department identified at least 40 different youth and adult gangs in the City, including 1,400 juvenile gang members. The Police Department’s Gang Task Force received 500 cases in 1994. These cases (involving youth and adult gangs) included 56 drive-by shootings (an increase of 37% over 1993), more than 50 gang-related robberies, over 155 gang-related assaults, and over 80 gang-related weapons seizures. The San Francisco Police Department associated the increase in violent crime with drugs and gang activity.<sup>5</sup> (Additional data on youth gang activity by age groups and race/ethnicity was not available.)

<sup>4</sup> Silbert, Mimi H., Delancey Street Foundation, *San Francisco Comprehensive Juvenile Justice Action Plan*, March 1997 (for the Mayor’s Criminal Justice Council and the California Board of Corrections)

<sup>5</sup> Silbert, Mimi H., Delancey Street Foundation, *San Francisco Comprehensive Juvenile Justice Action Plan*, March 1997 (for the Mayor’s Criminal Justice Council and the California Board of Corrections)

## DRUG AND ALCOHOL USE

Alcohol and drug use by adolescents can have immediate as well as long-term health and social consequences. Alcohol and illicit drug use by adolescents are risk-taking behaviors which contribute to deaths and injuries from accidents, suicides, and homicides. Alcohol and drug use are also associated with problems in school and in the workplace, and with violence and crime, including entry into the criminal justice system.<sup>1</sup> Abuse of alcohol and other drugs significantly increases the likelihood of risky behaviors that transmit sexually transmitted diseases including AIDS and other infectious diseases associated with injection drug use such as Hepatitis C.

Despite alcohol's legal status as a controlled substance, it is the most commonly used psychoactive substance among adolescents. Illicit drugs are also readily available to both adolescents and adults despite laws against their possession and/or use and laws establishing a variety of criminal penalties. Equally devastating, though less tangible, is the psychological and social damage on individuals, families, and communities that accompanies both alcohol and drug abuse.<sup>2</sup>

With respect to alcohol in particular, past efforts to address the problems of substance abuse among young people through prevention, treatment and law enforcement have had limited impact. Young people have received messages about individual-based strategies such as those focusing on the risks of alcohol and refusal skills. However, young people also have received other messages about alcohol, and its role in society and in coming of age, which can encourage alcohol use. More recently, there has been growing recognition that youth alcohol problems are the result of a complex web of factors such as community norms and practices and alcohol availability, and that an environmental approach to prevention must be used to tackle alcohol and drug problems as community problems with community-based solutions, rather than a matter primarily of individual behavior.<sup>3</sup>

### Data Sources

The extent of alcohol and illicit drug use among the San Francisco youth population can only be estimated due to the absence of population-wide data on substance use prevalence. This section includes data from a variety of sources in an attempt to identify and characterize the patterns and consequences of alcohol and drug use among the City's children and youth. It should be noted that the age groups used by the various data sources vary widely, as does the extent to which gender, race/ethnicity, and other breakdowns are available. The data sources include:

- The 1997 San Francisco Youth Risk Behavior Survey (YRBS) (preliminary results) conducted by the San Francisco Unified School District (in conjunction with the federal Centers For Disease Control). The 1997 YRBS surveyed 1,783 public middle school students (6<sup>th</sup> through 8<sup>th</sup> graders, ages 11 through 14 and older) and 1,914 public high school students (9<sup>th</sup> through 12<sup>th</sup> graders, ages

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<sup>1</sup> U.S. Public Health Service, Healthy People 2000: National Health Promotion and Disease Prevention Objectives (Conference Edition), D.C.: U.S. Department of Health and Human Services, September 1990; National Institute on Alcohol Abuse and Alcoholism, Ninth Special Report to the U.S. Congress on Alcohol and Health. From the Secretary of Health and Human Services, NIH Pub. No. 97-4017. MD: National Institutes of Health, June 1997

<sup>2</sup> U.S. Department of Health and Human Services, Healthy People 2000 Midcourse Review and 1995 Revisions.

<sup>3</sup> Mosher, J. "A Public Health Approach to Alcohol and Other Drug Problems: Theory and Practice," in Schuttfeld, F. and Keck, C., eds. Principles of Public Health Practice. Albany, NY: Delmar Publishers, 1996; Mosher, James, Preventing Alcohol Problems Among Young People: Californians Support Key Public Policies. Sacramento: California Center for Health Improvement.

15 to 18 and older). Selected results of the YRBS from prior years and for the nation as a whole also provided.

- San Francisco Medical Examiner's Annual Report, FY 1991/92 through FY 1995/96 provided data on drug caused deaths occurring in San Francisco among persons ages 0 to 29. These are deaths that occurred in San Francisco regardless of the individual's place of residence.
- Heroin/Opioid-Related Hospital Admissions, Trends and Regional Variations in California (1986-1995), a report by the Public Statistics Institute provided data on heroin/opioid-related hospital admissions in San Francisco of persons ages 0 to 24, from 1990 to 1996.
- Juveniles Arrested By Race and Sex 1994 - 1997 from the San Francisco Police Department provided data on narcotic and alcohol arrests among children and youth ages 0 to 17 from 1994 to 1997.
- Persons Killed and Injured in Alcohol-Involved Collisions By Age and By Victim Classification, 1994, 1995, 1996, a report by the California Highway Patrol, provided data on alcohol-involved motor vehicle collision deaths and injuries for persons ages 0 to 24.
- The National Drug Abuse Warning Network (DAWN) data collected by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services provided data on drug abuse episodes and drug mentions among persons entering hospitals with 24-hour emergency departments in the San Francisco metropolitan area (includes San Francisco, San Mateo, and Marin counties), from 1991 to 1994.

### **Alcohol And Drug Use Among Public School Students**

The Youth Risk Behavior Survey (YRBS) provides estimates of alcohol and drug use among San Francisco's public school students at the middle and high school level.<sup>4</sup> The survey asks students whether they have ever tried alcohol or drugs ("lifetime use") and whether they have tried alcohol or drugs within the past 30 days ("current use").<sup>5</sup> (Refer to the Appendix for detailed YRBS data.)

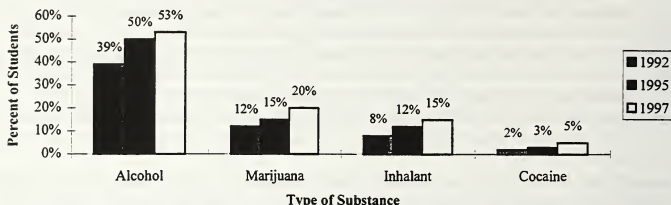
Lifetime Use of Alcohol and Drugs. Alcohol continues to be the most common substance used among San Francisco public middle and high school students. In 1997, over half of both middle school (53%) and high school (59%) students reported that they had tried alcohol at least once in their lifetime ("lifetime use"). Use of alcohol in middle school students increased since 1992 (39%), but had little change for high school students.

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<sup>4</sup> Refer to the Appendix for a general description of the YRBS methodology. [Or - briefly explain here?]

<sup>5</sup> Refer to the "Tobacco" section of this report for YRBS data on tobacco use.

**Lifetime Use of Alcohol and Drugs,  
Public Middle School Students, San Francisco, 1992, 1995, 1997**



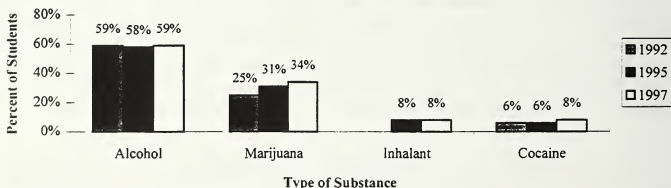
Source: San Francisco Unified School District, Youth Risk Behavior Survey, 1992; 1995; 1997 Preliminary Results

Marijuana was the second most common substance used among San Francisco public middle and high school students. One-fifth (20%) of middle school students reported ever having tried marijuana in 1997, compared to 12% in 1992. About one-third (34%) of high school students reported ever having tried marijuana in 1997, compared to 25% in 1992.

Lifetime cocaine use is low among students compared to other substances. However, lifetime use of cocaine increased from 2% to 5% among middle school students and from 6% to 8% among high school students between 1992 and 1997.

Lifetime inhalant use for middle school students nearly doubled from 1992 to 1997, increasing from 8% to 15%, while inhalant use among high school students remained stable at 8% during the same period. Examples of inhalants include glue, spray paint, chemo, and other chemicals.

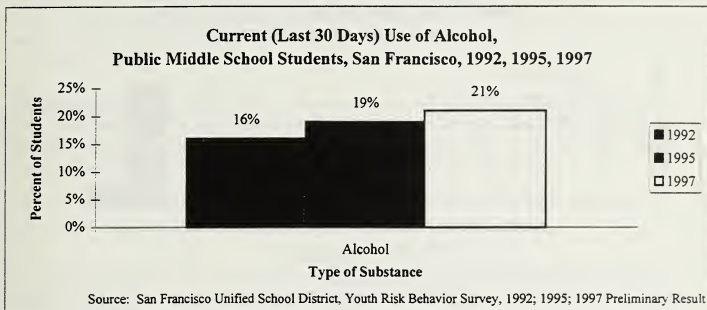
**Lifetime Use of Alcohol and Drugs,  
Public High School Students, San Francisco, 1992, 1995, 1997**



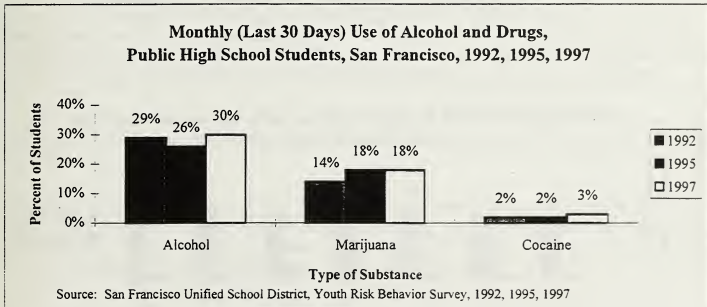
Source: San Francisco Unified School District, Youth Risk Behavior Survey, 1992; 1995; 1997 Preliminary Results

**Current Use of Alcohol and Drugs.** The YRBS indicated that current use of alcohol, marijuana, and cocaine use (within the last 30 days) is increasing among San Francisco public school students, although less dramatically than lifetime reported use. In 1997, one in five (21%) middle school

students and 30% of high school students reported using alcohol in the past 30 days. Alcohol use among these students is far from the Healthy People 2000 goal of reducing the proportion of youth ages 12 to 17 who have used alcohol in the past month to 12.6%.<sup>6</sup>



Marijuana use among high school students over the past 30 days increased from 14% to 18% between 1992 and 1997. In 1997, 3% of high school students reported that they used cocaine in the past 30 days. The YRBS did not ask middle school students about their use of marijuana and cocaine.<sup>7</sup>



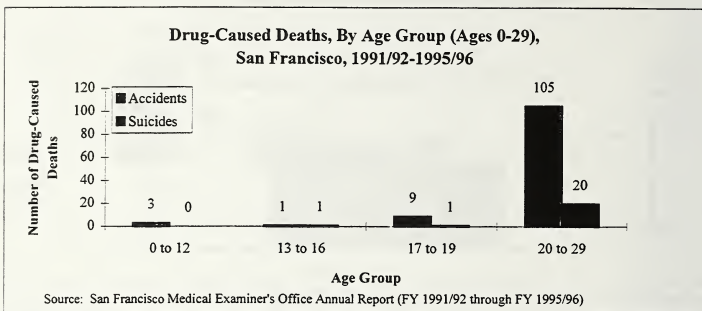
### Drug Caused Deaths

Between fiscal years 1991/92 and 1995/96, a total of 140 people up to age 29 died in San Francisco as a direct result of drug overdoses or drug reactions.<sup>8</sup> Most (84%) of these deaths were considered

<sup>6</sup> Note that some San Francisco middle school students surveyed in the YRBS were under age 12 and some high school students were over age 17, whereas the Healthy People 2000 objective for alcohol use sets the age range from 12 to 17.

<sup>7</sup> In the absence of data on middle school students, the Healthy People 2000 goal of reducing the proportion of youth ages 12 to 17 (both middle and high school levels) who have used marijuana in the past month to 3.2% and the proportion who have used cocaine in the past month to 0.6%, cannot be applied to San Francisco data.

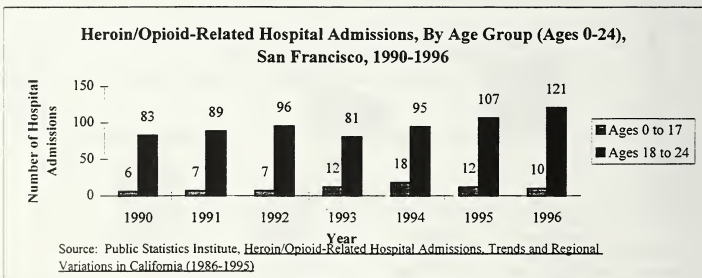
unintentional (“accidents”) while 16% (22) were considered suicides. Young adults in the 20 to 29 age group comprised 89% (125) of these deaths, followed by youth ages 17 to 19 who represented 5% (10)



of drug-caused deaths. The number of drug-caused deaths fluctuated from 22 to 34 deaths per year during the five-year period, averaging 24 drug-caused accidental deaths per year and 4 drug-caused suicides per year.

#### Heroin/Opioid-Related Hospital Admissions

From 1990 to 1996, there were an average of 106 heroin/opioid-related hospital admissions per year in San Francisco among persons up to 24 years old.<sup>9</sup> Young adults ages 18 to 24 accounted for 90% of these admissions. The number of admissions among youth under age 18 rose 47% from 1990 to 1996.



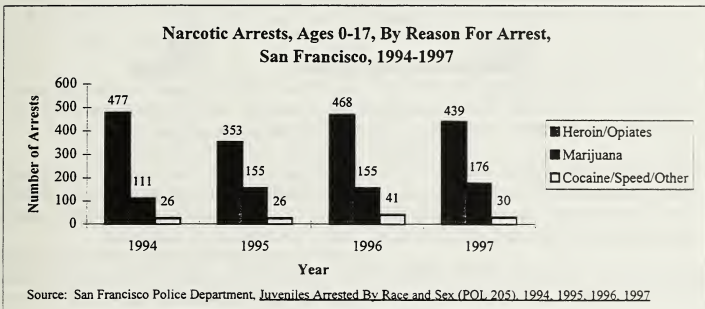
<sup>8</sup> Comparable data on alcohol-caused deaths is not available.

<sup>9</sup> Data on heroin/opioid-related hospital admissions was based on a study by the Public Statistics Institute (Irvine, CA) which reviewed medical charts to identify hospital admissions due to heroin/opioid abuse based on selected ICD-9-CM codes.

### Narcotic And Alcohol Arrests

From 1994 to 1997, there were a total of 2,834 arrests among juveniles through age 17 in San Francisco which were classified as narcotic (possession and sales) or alcohol (purchase and use) violations. This averages to 708 arrests per year or 14 arrests per week. (Note that arrests represent “events” rather than people. The number of arrests may reflect other factors in addition to the actual amount of crime occurring. Refer to the “Crime” section of this report for more discussion regarding arrest data.)

Reasons for Arrests. A majority (85%) of these arrests were narcotics-related, mainly for heroin/opiates (71% of narcotic arrests), followed by arrests for marijuana (24%). The number of arrests increased by 17% from 1990 to 1997, although narcotic arrests peaked in 1996. Arrests for cocaine/speed and “other” narcotics account for about 5% of narcotic arrests.



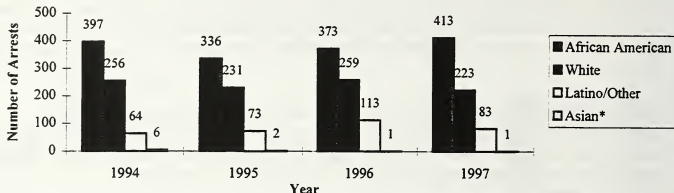
Alcohol arrests comprise only 6% of all narcotic and alcohol arrests. Violation of liquor laws such as under age drinking or drinking open containers were the most frequent type of alcohol arrest, with 24 to 37 arrests per year.

By Gender and Ethnicity. Three-fourths (73%) of juvenile narcotic and alcohol arrests from 1994 to 1997 were among males. More than half of all arrests (54%) were among African Americans, followed by 34% among Whites, 12% among Latinos and “Others”, and less than 1% among Asians.<sup>10</sup> During the four-year period, arrests among Latinos and Others rose by 30%.<sup>11</sup>

<sup>10</sup> “Asians” include Chinese and Japanese only. All other Asian subgroups fall under “other.”

<sup>11</sup> Data on arrestees by residence (e.g., zip code) was not available.

### Narcotic and Alcohol Arrests, Ages 0-17, By Race/Ethnicity, San Francisco, 1994-1997



Source: San Francisco Police Department, *Juveniles Arrested By Race and Sex (POL 205)*, 1994, 1995, 1996, 1997

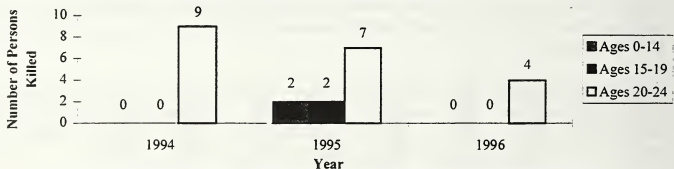
Note: "Asian" only includes Chinese and Japanese; other Asian subgroups within "Other."

### Alcohol-Involved Collisions - Deaths And Injuries

From 1994 to 1996, a total of 24 persons up to age 24 were killed in alcohol-involved collisions in San Francisco.<sup>12</sup> This includes drivers, passengers, and pedestrians. These deaths represent 2% of all alcohol-involved collisions, for all ages, reported for the same time period.

Most (83%) of these deaths were among young adults ages 20 to 24. Four deaths in 1996 among San Francisco youth ages 15 to 24 represents a rate of 4.4 deaths per 100,000, down from the 1994 rate of 9.9.<sup>13</sup> There was an overall decrease in the number of youth under age 25 killed in alcohol-involved collisions in San Francisco and California as a whole. San Francisco has achieved

### Persons Killed in Alcohol-Involved Collisions, By Age Group (Ages 0-24), San Francisco, 1994-1996



Source: California Highway Patrol, Information Services Unit, *Persons Killed and Injured in Alcohol-Involved Collisions By Age By Victim Classification*, 1994, 1995, 1996

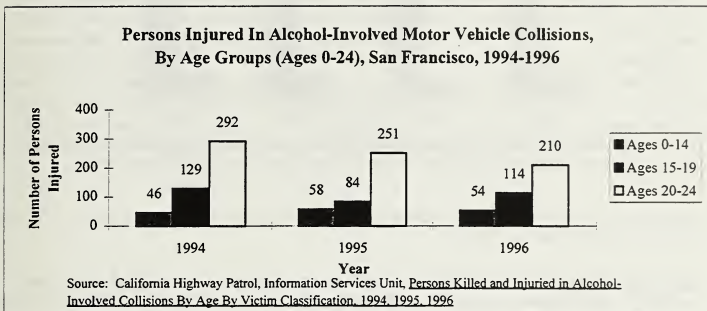
the Healthy People 2000 objective of reducing deaths caused by alcohol-related motor vehicle crashes to no more than 12.5 per 100,000 among people ages 15 to 24. Reductions in alcohol-related motor vehicle deaths and injuries are attributed to passage of state legislation, consistent with Healthy People

<sup>12</sup> Includes both residents and non-residents of San Francisco.

<sup>13</sup> Based on 1990 census data (total of 90,758 people ages 15 to 24 in San Francisco).

2000, to lower blood alcohol concentration level to 0.08 percent for people 21 years and over and to 0.02 percent and lower for drivers younger than 21.

From 1994 to 1996, 1,238 persons up to age 24 sustained non-fatal injuries in alcohol-involved collisions in San Francisco based on reports filed by the California Highway Patrol. The



number of injuries per year fluctuated among children and youth up to age 19, although injuries among young adults ages 20 to 24 declined by 28% from 1994 to 1996.

### Emergency Room Drug Episodes And Mentions

Data from the National Drug Abuse Warning Network (DAWN) provides another indicator of drug use based on a sampling of hospitals with 24-hour emergency departments.

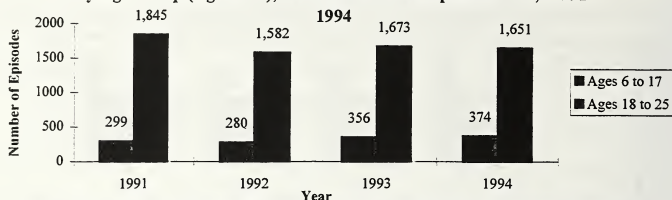
Emergency Room Drug Episodes. DAWN provides estimates of Emergency Room (ER) drug episodes, or ER admissions involving drug abuse.<sup>14</sup> From 1991 to 1994, there were an average of 2,015 emergency department drug abuse episodes per year or 5.5 episodes per day in the San Francisco metropolitan area among children and young adults ages 6 to 25.<sup>15</sup> These episodes represent about 17% of all drug abuse episodes for all ages in this geographic area. By comparison, it was 32% in Los Angeles and 33% in San Diego.

Among children and youth ages 6 to 25, young adults 18 to 25 years of age accounted for a majority of emergency room drug episodes (84%). Children and youth 6 to 17 years of age account for only 16% of episodes, although the number of episodes in this age group increased by 25%, from 299 to 374

<sup>14</sup> Patient identifiers are not collected and the episodes reported may include patients that make repeated visits to an ER or to several ERs.

<sup>15</sup> The San Francisco Metropolitan Area includes San Francisco, San Mateo, and Marin counties. Data for San Francisco County only was not available.

**Emergency Department Drug Abuse Episodes,  
By Age Group (Ages 6-25), San Francisco Metropolitan Area,\* 1991-**



Source: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network, October 1995

\* San Francisco Metropolitan Area includes San Francisco County, Marin County, and San Mateo County

episodes over the four-year period. Episodes among youth ages 18 to 25 declined from 1,845 episodes in 1991 to around 1,600 in 1994.<sup>16</sup>

Emergency Department Drug Mentions. DAWN data provides estimates of ER drug mentions, referring to an occurrence of a substance identified in a drug abuse episode.<sup>17</sup> In 1994, 3% (568) of all

**EMERGENCY DEPARTMENT MENTIONS,  
AGES 6-17, BY DRUG CATEGORIES, BY GENDER,  
SAN FRANCISCO METROPOLITAN AREA,\* 1994**

Drug Category	Gender		Total	
	Male	Female	#	%
Acetaminophen	16	53	69	12.1%
Alcohol-in-combination	25	38	63	11.1%
Marijuana/Hashish	43	19	62	10.9%
LSD	35	10	45	7.9%
Methamphetamine/Speed	16	19	35	6.2%
Cocaine	20	14	34	6.0%
Aspirin	0	30	30	5.3%
Over-the-Counter Sleep Aids	0	12	12	2.1%
All Other Drugs	74	144	218	38.4%
Total	229	339	568	100.0%

Source: Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network, October 1995 data file

\*Note: Includes San Francisco, San Mateo, and Marin counties.

<sup>16</sup> More recent data was not available.

<sup>17</sup> In addition to "alcohol-in combination," up to six substances can be reported for each ER drug abuse episode. The identified "drug mention" may not necessarily be the confirmed "cause" of the episode in multiple-drug cases.

emergency room drug mentions were among children and youth 6 to 17 years of age, while 77% (7,718) were among 18 to 34 year olds.<sup>18</sup> Drug mentions among children, youth, and young adults from ages 6 to 34 represented nearly half (47%) of all drug mentions for all ages in 1994. (Refer to the Appendix for more detailed data.)

Males comprised most (64%) drug mentions in the 18 to 34 age group, while females comprised the majority (60%) in the 6 to 17 age group. Individuals ages 18 to 34 used a wider variety of drugs compared to the 6 to 17 age group. Excluding the "All Other Drugs" category, the top five ranking drug categories for both 6 to 34 year olds and 18 to 34 year olds were cocaine, heroin/morphine, alcohol-in-combination, methamphetamine/speed, and marijuana/hashish. The top ranked drug categories among 6 to 17 year olds were acetaminophen, alcohol-in-combination, marijuana/hashish, LSD, and methamphetamine/speed. Note that DAWN data does not attempt to determine the intent (unintentional or intentional), or purpose of drug use (for example, recreational, medicinal, or suicide).

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<sup>18</sup> Data was provided in these designated age groups.

## TOBACCO

Tobacco use is the single most preventable cause of death and disease and is responsible for about one of every seven deaths (14%) in San Francisco and one of five deaths in California and in the U.S.<sup>1</sup> Health problems caused by tobacco include heart disease, cancer, respiratory illness, and stroke, and smokeless tobacco use causes oral cancer and other oral health problems. In addition, exposure to environmental tobacco smoke is responsible for some lung cancer deaths in nonsmokers.<sup>2</sup>

It is estimated that one-third of adolescents who begin smoking will eventually die from tobacco-related illnesses.<sup>3</sup> Many studies have shown that individuals who develop a tobacco addiction experience tremendous difficulties and high failure rates when attempting to quit.<sup>4</sup> The overwhelming evidence of the addictive nature of nicotine underscore the need to prevent tobacco use among young people through enforcement of youth access laws, effective prevention education programs in the schools and community, and media campaigns targeted at youth.<sup>5</sup>

### Data Sources

Data for this section were from 2 sources:

- The 1997 San Francisco Youth Risk Behavior Survey (YRBS) conducted by the San Francisco Unified School District (in conjunction with the federal Centers for Disease Control). The YRBS asked students to report their history of and current use of cigarettes and smokeless tobacco products. In addition, the survey asked students about attempts to quit smoking and methods of obtaining tobacco products.
- The California Tobacco Survey (CTS) conducted by the California Department of Health Services, Tobacco Control Program (1990; 1993; 1996). The CTS was designed to provide statewide estimates of tobacco use trends including estimates of attitudes, behavior, and media exposure regarding smoking and tobacco use. Due to the small sample size, estimates for the county level, especially data pertaining specifically to adolescents is limited. Data was collected via household telephone interviews.

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<sup>1</sup> Centers for Disease Control and Prevention. "Cigarette Smoking-Attributable Mortality and Years of Potential Life Lost - United States, 1990." Morbidity and Mortality Weekly Report. 1993. San Francisco estimate is for the period 1990 to 1995.

<sup>2</sup> Environmental Protection Agency. Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. EPA/600/6-90, 1992.

<sup>3</sup> Johnston, L.D., O'Malley, P.M., and Bachman, J.G. National Trends in Drug Use and Related Factors Among American High School Students and Youth Adults, 1975-1986. U.S. Department of Health and Human Services (DHHS) Publication No. (ADM) 87-1535, Rockville, MD: National Institute on Drug Abuse, 1987.

<sup>4</sup> U.S. Department of Health and Human Services. The Health Consequences of Smoking: Nicotine Addiction. A Report to the Surgeon General. 1988. DHHS Publication No. (CDC) 88-8406; 1988.

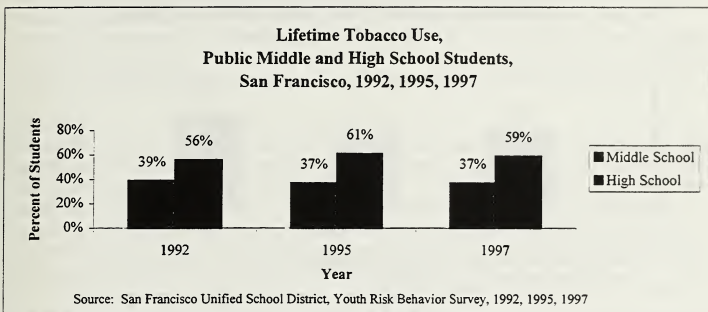
U.S. Department of Health and Human Services. The Health Benefits of Smoking Cessation. A Report to the Surgeon General. 1988. DHHS Publication No. (CDC) 90-8416; 1990.

Hunt, W.A., Barnett, L.W., Branch, L.G. "Relapse Rates in Addiction Programs." Journal of Clinical Psychology. 1971; 27 (4): 455-456.

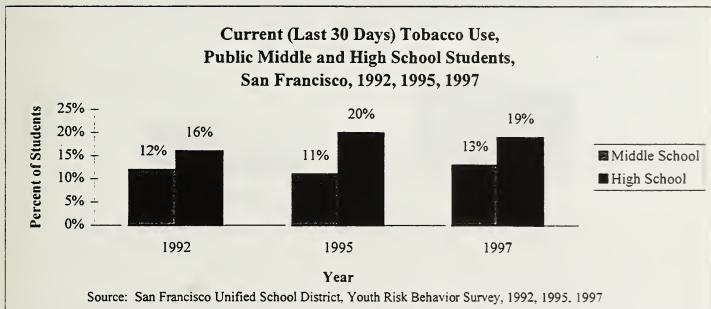
<sup>5</sup> Proposition 99 established as a key objective for the California Tobacco Control Program the prevention of the onset of tobacco use in young people.

### Estimates of Smoking Prevalence

The 1997 San Francisco YRBS estimated that over one-third (37%) of middle school students and over half (59%) of high school students reported that they had tried smoking at least once in their lifetime.

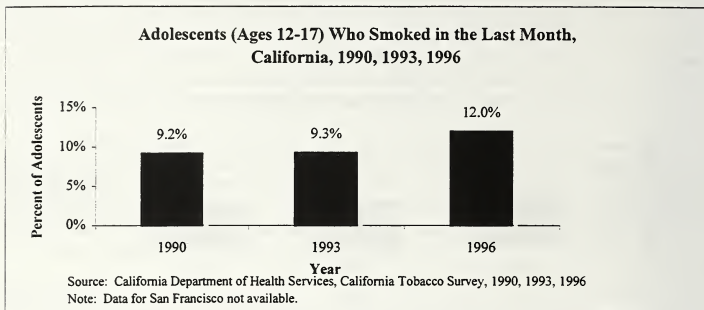


Estimates of smoking prevalence in the last 30 days among adolescents varies depending on the survey. According to the 1997 YRBS, 13% of San Francisco's middle school students reported that they had smoked cigarettes during the past 30 days; over half (57%) of these recent smokers had smoked five days or less. Nearly one in five San Francisco high school students (19%) reported that they had smoked cigarettes at least once in the previous month, including 5% who had smoked regularly (daily), and 9% who had smoked cigarettes on school property.



The California Tobacco Survey (CTS), conducted by the California Department of Health Services, provided an alternate estimate of smoking prevalence among youth. County level estimates are not available due to the small sample size. The percentage of adolescents ages 12 to 17 statewide who smoked in the past month remained constant at 9.2% and 9.3% in 1990 and 1993 but increased by three percentage points to 12.0% in 1996. The CTS report acknowledged the variation between school

surveys, which tend to provide inflated estimates, and household surveys which tend to provide deflated estimates of smoking prevalence.<sup>6</sup>



Among subgroups of adolescents statewide, the CTS reported that Asians, Hispanics, and those with better than average school performance showed increases in smoking rates by over 50%.

### **Smokeless Tobacco Use**

According to the 1997 YRBS, 8.5% of middle school students reported that they used chewing tobacco or snuff (such as Redman, Skoal Bandits, or Copenhagen) at least once in their lifetime. Two percent of high school students reported that they had used smokeless tobacco during the past 30 days. According to the 1993 CTS, 7% of adolescent males (ages 12 to 17) in San Francisco reported using chewing tobacco or snuff in the previous 30 days, compared to 14% of their counterparts in the rest of California.

<sup>6</sup> California Department of Health Services, Tobacco Control Program, 1996 California Tobacco Survey: Early Results; California Department of Health Services, "California Announces New Rates of Smoking For Adults and Youth" (press release), March 25, 1997.

## SEXUAL BEHAVIOR

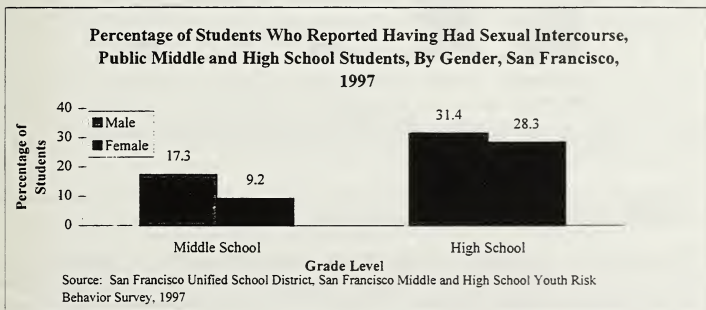
Early sexual activity and multiple sexual partners are associated with unintended pregnancy and sexually transmitted diseases (STDs) including HIV infection. Sexual intercourse during the adolescent years, especially first intercourse, is often unplanned, and as a result is often unprotected from STDs and pregnancy by contraception.<sup>1</sup> Alcohol and drug use may contribute to unsafe sexual activity by lowering inhibitions and impairing judgement, especially among adolescents.<sup>2</sup>

### Data Source

This section will present data on patterns of sexual behavior among middle and high school students in San Francisco public schools based on the 1997 San Francisco Youth Risk Behavior Survey (YRBS) conducted by the San Francisco Unified School District (in conjunction with the federal Centers for Disease Control). The YRBS asked students to report their lifetime and recent sexual activity including use of contraception and use of alcohol and drugs before sexual activity. Refer to the "Perinatal Health," "Sexually Transmitted Diseases," and "HIV/AIDS" sections of this report for additional information on the outcomes of sexual behavior.

### Sexual Behavior Among Middle and High School Students

**Lifetime and Recent Sexual Activity.** In 1997, 14% of San Francisco middle school students reported that they had engaged in sexual intercourse at least once, with males almost twice as likely as females (17% vs. 9%). In 1995, 10% of middle school students reported having had sexual intercourse compared to 16% in 1991.



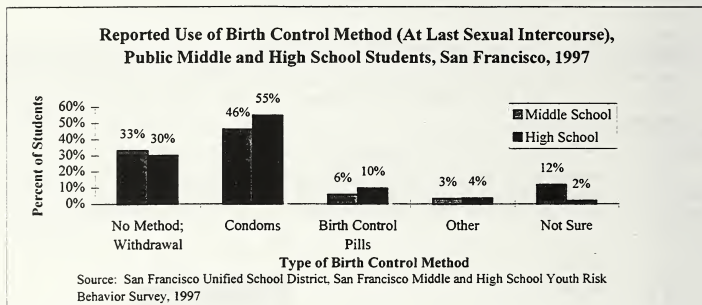
<sup>1</sup> Lowenstein, G. and Fustenberg, F.F. 1991. "Is Teenage Sexual Behavior Rational?" *Journal of Applied Social Psychology* 21 (12): 957-986. Forrest, J.D. and Singh, S. 1990. "The Sexual and Reproductive Behavior of American Women, 1982-1988." *Family Planning Perspectives* 22(5): 206-214.

<sup>2</sup> National Research Council. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. D.C.: National Academy Press, 1987.

In 1997, at the high school level, 31% of males and 28% of females reported having engaged in sexual intercourse, compared to the national rate of 53% (1995).<sup>3</sup> In 1997, 2.5% of San Francisco male high school students and 1.2% of female high school students reported having had sexual contact with a member of the same gender. Middle school students were not asked about sexual activity with persons of the same gender.

**Number of Partners.** Among sexually-experienced students, more middle school students (45%) than high school students (39%) reported that they had already had sex with three or more partners.

**Use of Contraception: Source for Condoms.** Among those stating that they had sexual intercourse, about one-third of middle school students (33%) and high school students (30%) reported using no method of protection or used withdrawal the last time they had sex. Among all contraceptive methods, condoms were the most commonly reported birth control method used by both middle (46%) and high school students (55%). Among middle school students, 12% were not sure of what method was used. Ten percent of high school students and 6% of middle school students reported using birth control pills.



High school students who used condoms said they got condoms from a store (26%), from a condom availability program at school (24%), or from a friend or relative (22%).<sup>4</sup>

**Use of Alcohol/Drugs: Pregnancy.** Twice as many middle school students (31%) compared to high school students (15%) said they used alcohol or drugs before the last time they had sexual intercourse. Among high school students who said they have had sex, 16% said they have been pregnant or gotten someone pregnant at least once.

<sup>3</sup> The national rate for middle school students was not available.

<sup>4</sup> Middle school students were not asked where they obtained condoms.

## DIETARY AND EXERCISE PATTERNS

Establishing healthy eating and physical exercise habits at an early age is important. Both dietary and exercise patterns formed during childhood can carry into adulthood producing life-long health benefits.<sup>1</sup>

Importance of Healthy Dietary Practices. High fat diets are associated with increased risk of obesity, heart disease, diabetes mellitus, some types of cancer, and other health problems.<sup>2</sup> Furthermore, people often consume high fat foods while failing to eat foods high in complex carbohydrates and dietary fiber, both of which contribute to good health.<sup>3</sup> High calorie intake, in combination with lack of physical activity, is thought to account for increases in obesity among adolescents. It is estimated that adolescents in the U.S. get an average of 38% of their calories from fat, more than is recommended by health experts.

Individuals who are overweight in adolescence are at greater risk of being overweight as adults. One in five (21%) adolescents in the U.S. are overweight, and the prevalence has increased over the past decade.<sup>4</sup> To reverse this trend, young people need to increase the nutritive value of the foods they eat, reduce their fat intake, increase their fruit and vegetable intake, and engage in more physical activity.

Society's emphasis on being thin contributes to the prevalence of eating disorders, such as anorexia nervosa (a disease in which people severely limit their food intake), and bulimia (a disease which involves excessive overeating followed by episodes of "purging" through vomiting, use of laxatives, or compulsive exercising).<sup>5</sup> Although eating disorders are most common in young females, an estimated 5 to 10% of eating disorders occur in males. About one in ten cases of eating disorders lead to death from starvation, cardiac arrest, or suicide.<sup>6</sup>

Importance of Regular Physical Activity. Regular physical activity increases life expectancy and reduces the risk of many health problems including heart disease, high blood pressure, cancer, osteoporosis, diabetes mellitus and mental health problems (such as depression and anxiety). Vigorous physical activity is associated with a wide range of positive health outcomes for children and youth

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<sup>1</sup> U.S. Department of Health and Human Services, Public Health Service. Chronic Diseases and Health Promotion. Reprints from the Mortality and Morbidity Weekly Report: 1990-1991 Youth Risk Behavior Surveillance System. Note: "Vigorous exercise" is defined as activities that cause sweating and hard breathing for at least 20 minutes.

<sup>2</sup> Public Health Service. (1988). The Surgeon General's Report on Nutrition and Health, 1988. Washington, DC: U.S. Department of Health and Human Services, Public Health Service Pub. No. (PHS) 88-50210.

<sup>3</sup> Public Health Service. (1988). The Surgeon General's Report on Nutrition and Health, 1988. Washington, D.C.: U.S. Department of Health and Human Services Pub. No. (PHS) 88-50210. Washington, DC: U.S. Department of Health and Human Services.

<sup>4</sup> Center for Disease Control and Prevention. (1994). "Prevalence of Overweight Among Adolescents - United States, 1988-91." Morbidity and Mortality Weekly Report, 43 (44). Note: Healthy People 2000 objective 1.2 refers to reducing overweight to no more than 15% among adolescents ages 12 to 19. (U.S. baseline in 1976-80 was 15% for adolescents ages 12 to 19.) Data on overweight prevalence among San Francisco youth is not available.

<sup>5</sup> National Institute of Mental Health. (1993). Eating Disorders. U.S. Department of Health and Human Services, NIH Pub. No. 93-3477. Note: In the U.S., approximately 1% of adolescent females develop anorexia nervosa, and an additional 2 to 3% of adolescent females develop bulimia.

<sup>6</sup> Stein, R.F. (1987). "Comparison of Self-Concept of Nonobese and Obese University Junior Female Nursing Students." Adolescence, 22: 77-90.

including reduced rates of obesity and hypertension, increased self-esteem, and decreased rates of teen pregnancy.<sup>7</sup>

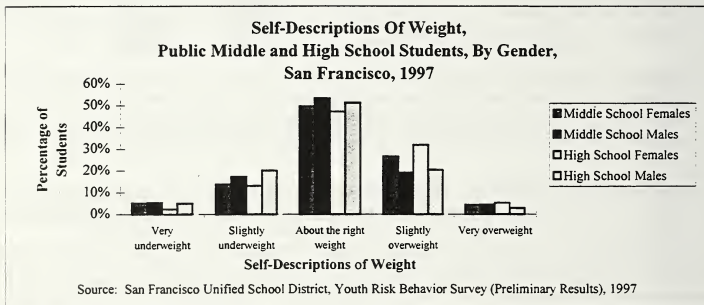
Physical education programs at school have been found to have a positive effect on the health of young people.<sup>8</sup> Despite the growing evidence of the benefits of regular physical activity, our society is becoming more sedentary, and an important public health challenge is for people of all ages to adopt more physically active lifestyles and behaviors.

### Data Source

Data for this section was obtained from the 1997 San Francisco Youth Risk Behavior Survey (YRBS) conducted by the San Francisco Unified School District. The San Francisco YRBS asked students in San Francisco public middle and high schools to report self-perceptions of their body weight, efforts to change/maintain body weight, food choices, exercise patterns, and behaviors that may indicate eating disorders or other health problems.

### Self-Perceptions of Weight

When asked how they perceived themselves in terms of weight, only about half of middle and high school students consider their weight to be "about right" (52% and 49%). Twenty-seven percent of middle and 30% of high school students said they were slightly or very overweight and 21% of middle school and 20% of high school students said they were slightly or very underweight. Females were more likely than males to consider themselves overweight than males, in both middle (31% vs. 24%) and high school (37% vs. 24%). (Refer to detailed data in the Appendix.) Perceptions of weight have remained relatively stable since 1991.

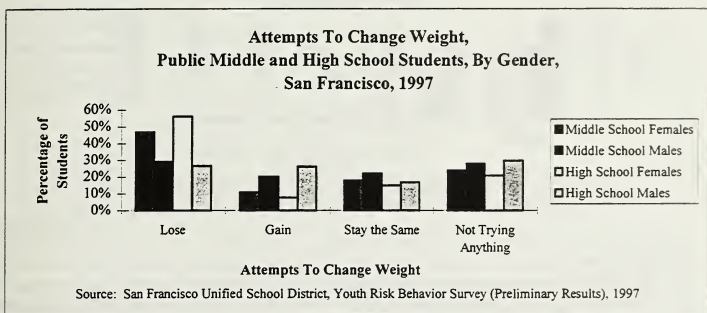


About three-fourths of middle and high school students (74% and 75%) had attempted to change their weight, either lose weight, gain weight, or stay the same weight. The remainder of students had not tried to do anything about their weight. About four out of ten middle school (38%) and high school

<sup>7</sup> The President's Council on Physical Fitness and Sports, *Physical Activity and Sport in the Lives of Girls*, Washington, D.C.

<sup>8</sup> U.S. Department of Health and Human Services. (1985). "National Children and Youth Fitness Study, I and II." *Journal of Physical Education, Recreation, and Dance*, 56: 44-90 and 58: 50-96.

(41%) students reported that they were trying to lose weight.<sup>9</sup> Again, significantly more females than males reported attempting to lose weight, in both middle (47% vs. 29%) and high school (56% vs. 27%). (Refer to detailed data in the Appendix.) The proportion of students trying to lose weight have increased slightly since 1995, when it was 35% of middle school and 39% of high school students.

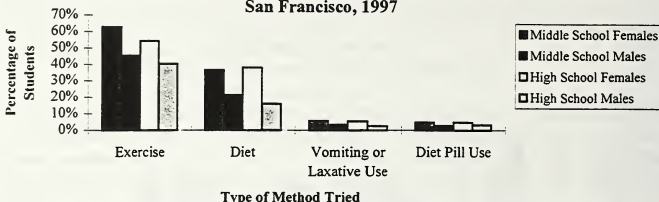


About half of students reported exercising (54% of middle school and 47% of high school) as a way to lose or keep from gaining weight. Many students reported that they dieted (29% of middle and 27% of high school).<sup>10</sup> A small percentage of students reported using unsafe weight control techniques, such as vomiting or taking laxatives (5% in middle and 4% in high school), and taking diet pills (4% in both middle and high school) in order to lose or keep from gaining weight. Use of unsafe methods was more common among females than males, in both middle and high school. (Refer to detailed data in the Appendix.)

<sup>9</sup> Middle school students were asked what they had ever tried to lose weight (lifetime); high school students were asked whether they had tried to lose weight within the past 30 days (current).

<sup>10</sup> Middle school students were asked what they had ever done to change their weight (lifetime); high school students were asked what they had done within the past 30 days to change their weight (current).

**Methods Tried To Lose or Keep From Gaining Weight,  
Public Middle and High School Students, By Grade Level and Gender,  
San Francisco, 1997**



Source: San Francisco Unified School District, Youth Risk Behavior Survey (Preliminary Results), 1997

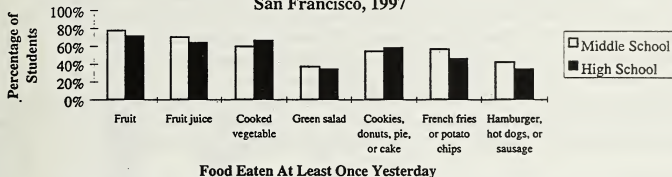
### Dietary Patterns

The 1997 YRBS asked students about their food intake on the day before completing the survey. About three-fourths of middle (77%) and high school (71%) students said that they ate fruit, and most (70% of middle; 64% of high school) drank fruit juice at least once on the day before the survey. Most middle and high school students ate cooked vegetables at least once (60% of middle and 66% of high school) while only one-third ate green salad at least once the day before the survey (37%; 34%).<sup>11</sup>

Both middle and high school students reported they they had, on the day before the survey, consumed foods typically high in fat content including hamburgers, hot dogs, or sausage (42% of middle and 34% of high school), french fries or potato chips (57% and 46%), and cookies, doughnuts, pie, or cake (54% and 58%).

<sup>11</sup> Healthy People 2000 objective 2.6 refers to increase complex carbohydrate and fiber-containing foods in the diets of people ages 2 and older to an average of 5 or more daily servings for vegetables and fruits, and to an average of 6 or more daily servings for grain products.

**Foods Eaten At Least Once Yesterday,  
Public Middle and High School Students,  
San Francisco, 1997**



Source: San Francisco Unified School District, Youth Risk Behavior Survey (Preliminary Results), 1997

### Exercise Patterns

A majority of students reported that they had engaged in aerobic exercise three or more days in the previous week, although the percentage is much higher for middle school students (74%) compared to high school students (52%). This indicates that middle school students have nearly reached the Healthy People 2000 objective 1.4 that at least 75% of children and adolescents ages 6 to 17 engage in vigorous physical activity at least 3 days per week.<sup>12</sup> The percentage of students engaging in aerobic exercise for three or more days in the week has been relatively stable since 1991 for middle school students and has dropped since 1993 for high school students (62%).

About half of both middle school (50%) and high school students (46%) said they did strengthening exercises three or more days in the previous week, or slightly higher than in 1995 (46% and 41%, respectively). This indicates that San Francisco adolescents have achieved the Healthy People 2000 objective 1.6 that 40% of people ages 6 and older regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility.

Nearly all (96%) of middle school students reported usually going to physical education class at least one day a week, and 87% usually go for five days a week. However, the level of attendance at physical education classes at the high school level is significantly lower, with only 38% attending physical education class five days a week, and 48% not attending at all. San Francisco's middle school adolescents have achieved the Healthy People 2000 objective 1.8 that at least 50% of children and adolescents in the 1st through 12th grade participate in daily school physical education. However, high school adolescents have fallen short of reaching the objective.

<sup>12</sup> Data on exercise levels of San Francisco children younger than the middle school level is not available.

## HEALTH INSURANCE

The health of children depends at least partially on their access to health services. Children with access to health care have reasonable assurance of obtaining the medical and dental attention needed to maintain their physical well-being. Health care for children includes physical examinations, preventive interventions and education, screening, and immunizations, as well as sick care. Access involves both the availability of a regular source of care and the ability of the child's family, or someone else, to pay for it. Children with health insurance (public or private) are much more likely than children without health insurance to have a regular and accessible source of health care.<sup>1</sup> Regular health care increases the continuity of care, which helps to maintain good health.<sup>2</sup>

### Data Sources

The majority of data provided in this section comes from various reports utilizing data from the Current Population Survey (CPS), administered by the U.S. Census Bureau.<sup>3</sup> The reports include:

- 1.6 Million California Children Are Uninsured by Nadereh Pourat, E. Richard Brown, and Roberta Wyn, University of California, Los Angeles, Center for Health Policy Research, March 1997 (based on the March 1996 CPS);
- The State of Health Insurance in California, 1997, by Helen Halpin Schauffler, University of California, Berkeley, and E. Richard Brown, UCLA Center for Health Policy Research (based on the March 1997 CPS);
- San Francisco County Estimates of Health Insurance, by Andrew Bindman, University of California, San Francisco, December 19, 1997 (based on the 1997 and 1996 CPS).

### Estimates of Uninsured Children and Youth

San Francisco County. In 1996 and 1997, children and youth ages 0 to 17 were estimated to comprise an average of about 9% (11,700) of the uninsured population (130,000) in San Francisco. In 1997, the estimated number of uninsured residents ages 0 to 17 or 10,517 or 7% of the uninsured population, and for 1996 the estimate was 13,093 or 11% of the uninsured population. The proportion of San Francisco residents ages 0 to 17 without health insurance was much lower than the proportion of San Francisco residents of all ages without health insurance in both 1997 (21%; 159,530) and 1996 (17%; 117,855).<sup>4</sup> (According to the study, data from 1996 to 1997 suggesting that the number of uninsured in San Francisco for all ages may have grown over time could represent a real trend or be an artifact of the data collection.)<sup>5</sup>

<sup>1</sup> Federal Interagency Forum on Child and Family Statistics. America's Children: Key National Indicators of Well-Being, 1998. Federal Interagency Forum on Child and Family Statistics, D.C.: U.S. Government Printing Office, 1998; National Center for Health Statistics, "Health of Our Nation's Children," Vital Statistics Health Series, 10 No. 191, 1998.

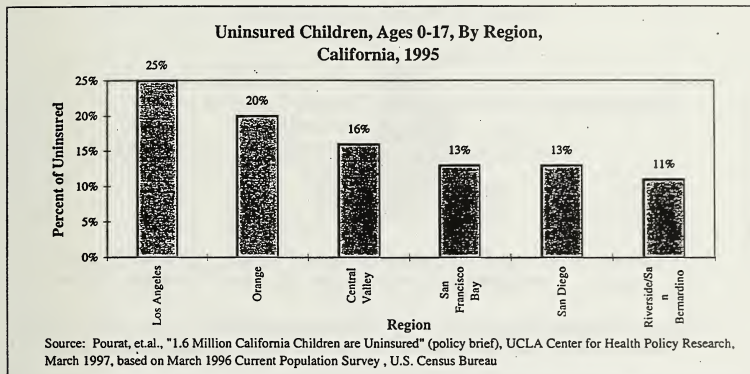
<sup>2</sup> U.S. Department of Health and Human Services, Trends in the Well-Being of America's Children and Youth: 1996, April 1996

<sup>3</sup> The CPS is conducted annually to provide updates to the census performed every decade. Information on health insurance status is obtained annual in March. The sampling was designed to provide estimates at the national and state levels, and sample sizes at the county level are small and subject to wide variation due to error. In 1996, 208 San Francisco residents provided data about their health insurance status and in 1997 the sample size for the county was 233.

<sup>4</sup> The 95% confidence interval for the estimate of San Francisco uninsured was 15 to 26% (115,995 to 201,057) in 1997 and 11 to 22% (76,357 to 152,714) for 1996.

<sup>5</sup> Bindman, Andrew, San Francisco County Estimates of Health Insurance, December 19, 1997. The lower and upper percentage estimates of uninsured persons in San Francisco were 15% and 26%, respectively. These lower and upper estimates describe a range for which there is a 95% chance that the true number of uninsured actually lies somewhere in

**San Francisco Bay Area.** An estimated 10% of children and youth ages 0 to 17 in the six-county San Francisco Bay Area were uninsured in 1995.<sup>6</sup> This percentage was lower than several regions in the state, including Los Angeles County which had the highest percentage of uninsured children and youth (25%) compared to



all other regions surveyed. In general, counties with large populations of immigrant workers, or those counties with large agricultural or durable goods manufacturing industries, tended to have higher rates of uninsured residents.

**California.** The proportion of children and youth who are uninsured in San Francisco is generally lower than the proportion statewide. In 1997, the proportion of California children ages 0 to 17 who lacked health insurance was 17% (1.6 out of 9.1 million) while the percentage of children ages 0 to 18 for 1996 was estimated at 18% (1.7 million).<sup>7</sup> California's rate of uninsured children is higher than the national average of 15% (1996).<sup>8</sup>

between (95% confidence interval). Gender, race/ethnicity, and poverty status data for the uninsured San Francisco population under age 18 was not available due to the small sample size of the CPS dataset.

<sup>6</sup> The six counties in the "San Francisco Bay Area" region were San Francisco, Marin, San Mateo, Alameda, Contra Costa, and Santa Clara. Data for San Francisco County only was not available from this source. Not all California counties were analyzed.

<sup>7</sup> Schauffler, Helen Halpin, and E. Richard Brown, *The State of Health Insurance in California, 1997*; Pourat, Nadereh, et.al.

<sup>8</sup> U.S. Census Bureau, Housing and Household Economic Statistics Division, March Current Population Survey

By Gender. In 1996, there were no gender differences in the proportion of California children and youth ages 0 to 18 who were uninsured. However, lack of insurance was much more common among males ages 19 to 24

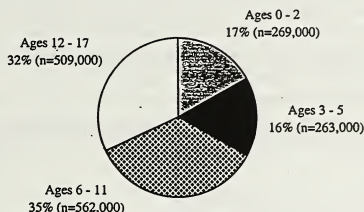
HEALTH INSURANCE COVERAGE, BY AGE AND GENDER, AGES 0-24, CALIFORNIA, 1996					
<u>Age and Gender</u>	Uninsured	Job-Based Insurance	Privately Purchased Coverage	Medi-Cal	Other Public Insurance
Age 0-18					
Males	18%	54%	4%	22%	1%
Females	18%	54%	4%	23%	1%
Age 19-24					
Males	48%	39%	6%	7%	0%
Females	33%	45%	5%	16%	1%
Source: Schauffler, Helen Halpin, and E. Richard Brown, <u>The State of Health Insurance in California, 1997</u> (based on 1997 CPS)					

(48%) than among females in the same age group (33%). This difference is due the fact that more females than males in this age group receive Medi-Cal (16% vs. 7%) and employment-based health insurance (45% vs. 39%).<sup>9</sup>

By Age. In 1995, children ages 0 to 5 represented one-third (33%) of California's uninsured children and youth up to age 17. Of these, about half were infants and toddlers under 3, and about half were

<sup>9</sup> Schauffler and Brown, 1997

**Uninsured Children, By Age Groups, Ages 0-17,  
California, 1995**



Source: Pourat, et. al, UCLA Center for Health Policy Research, "1.6 Million California Children Are Uninsured" (policy brief), March 1997 (based on U.S. Census Bureau, March 1996 Current Population Survey)

preschool children ages 3 to 5. An additional 35% of California's uninsured children were ages 6 to 11, while adolescents ages 12 to 17 accounted for the remaining 32%.

**By Race/Ethnicity.** Availability of health insurance coverage among children and youth in California varies widely by race/ethnicity. In 1995, 29% of Latino children in California were without health insurance. This was more than twice the rate for Asian children (12%), non-Latino Whites (10%), and African American children

**Uninsured Children, By Ethnicity, Ages 0 - 17,  
California, 1995**

	Latino	Asian American	Non-Latino White	African American
All Children	29% (1,200,000)	12% (136,000)	10% (370,000)	10% (69,000)
Children in Full-Time Working Families	31% (634,000)	14% (94,000)	8% (208,000)	8% (*)

Source: Pourat, et.al., UCLA Center for Health Policy Research, "1.6 Million California Children Are Uninsured," March 1997 (based on data from the U.S. Census Bureau, Current Population Survey, March 1996).

\* Notes: Sample size is too small to be reliable.

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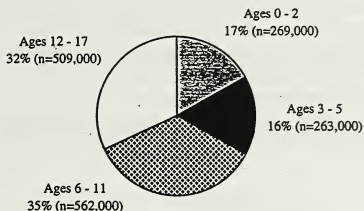
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<sup>9</sup> Schauffler and Brown, 1997

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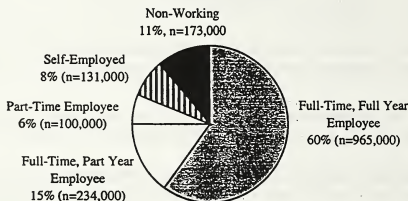
Source: Pourat, et.al., UCLA Center for Health Policy Research, "1.6 Million California Children Are Uninsured," March 1997 (based on data from the U.S. Census Bureau, Current Population Survey, March 1996).

\* Notes: Sample size is too small to be reliable.

(10%). Even among children in full-time working families, the uninsured rate for Latino children was high (31%), more than twice that of any other ethnic group including 14% of Asian American children and 8% of non-Latino white and African American children.<sup>10</sup>

**By Family Work Status.** Having working parents does not ensure health insurance coverage for California's children. In 1995, most (89%) uninsured children in California lived in families with at least one working parent. Sixty percent of uninsured children were in families with at least one parent employed full-time for the entire year. Another 21% of uninsured children lived in families with a parent working part-time or for part of the year, and 8% were in self-employed families. Only 11% of uninsured children were in families without a working parent.

**Uninsured Children, By Family Work Status, Ages 0-17, California, 1995**



Source: Pourat, et. al, UCLA Center for Health Policy Research, "1.6 Million California Children Are Uninsured" (policy brief), March 1997 (based on U.S. Census Bureau, March 1996 Current Population Survey)

Ironically, the lowest uninsured rate among children was in families without a working adult. In 1995, only 13% of children in non-working families in California were uninsured, because Medi-Cal protected 77% of children in these families.

**Sources of Insurance.** In 1996, 54% of California's insured children received health insurance through employer-sponsored plans, compared to 50% in 1994. Twenty-two percent of insured children obtained health insurance coverage through Medi-Cal in 1996, compared to 25% in 1994. Only 4% of insured children were covered by privately-purchased health insurance, compared to 3% in 1995.<sup>11</sup>

Children of working parents are not covered by employment-based insurance for several reasons:

- Often, an employer offers a health plan, but an employee may receive wages too low to afford it. Generally, employers in California pay between 60% and 70% of the costs of employment-based family coverage. The cost to employees ranges from \$140 to \$210 per month.<sup>12</sup> Sixty percent of

<sup>10</sup> These are the racial/ethnic categories designated by the authors of the study.

<sup>11</sup> Pourat, 1997

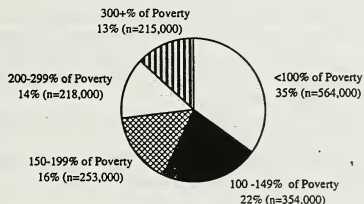
<sup>12</sup> Schauffler, 1997

uninsured Californians indicate high cost as the main reason they do not have health care coverage.<sup>13</sup>

- An employee may be able to afford his or her work-based health insurance but the plan may not extend to the rest of the family.
- Insurance may not be portable between jobs.
- Traditional barriers, such as culturally incompetent care, physical inaccessibility, and language differences may impede access to employment-based health coverage.<sup>14</sup>

**By Income/Poverty Level.** There is a direct correlation between low-income status and lack of health insurance. Children from low-income, working families frequently do not have access to employer-sponsored health insurance coverage due to the nature of their parent or guardian's type of employment. These same families may not qualify for Medi-Cal, and can not afford the costs of privately-purchased insurance. As a result, children in low-income situations with working parents are without health care coverage.

**Uninsured Children, By Poverty Level, Ages 0-17,  
California, 1995**



Source: Pourat, et. al, UCLA Center for Health Policy Research, "1.6 Million California Children Are Uninsured" (policy brief), March 1997 (based on U.S. Census Bureau, March 1996 Current Population Survey)

In 1995, a majority of uninsured children in California were low-income, with more than one-third (35%) of uninsured children living in families with incomes below the federal poverty level (defined in 1995 as less than \$12,158 for a family of three and less than \$15,569 for a family of four). Another 38% were near poor, with family incomes between the poverty level and twice the poverty level. Thus, three-quarters of uninsured children (1.2 million) could be considered to be in families with too few resources to pay for health insurance coverage.

<sup>13</sup> Brown, E. Richard, et. al., The Uninsured in California: Causes, Consequences and Solutions. Final Report to the California HealthCare Foundation, September, 1997.

<sup>14</sup> Schauffler, 1997

## MEDI-CAL (MEDICAID)

Medicaid is the nation's major publicly-financed program, jointly financed by the federal and State governments, for providing health insurance to low-income people. Authorized in 1965 under Title XIX of the Social Security Act, Medicaid acts as a safety net for those unable to purchase health insurance. At the federal level, the Health Care Financing Administration (HCFA) oversees the Medicaid program. In California, the Medicaid Program is known as Medi-Cal, and is administered by the Department of Health Services. At the local level, county welfare departments determine the eligibility of applicants for Medi-Cal (San Francisco Department of Human Services).

### Eligibility

Being poor does not automatically qualify a person for Medi-Cal. Only persons who fall into particular "categories" such as people receiving cash assistance or low-income children and pregnant women are eligible. In California, Medi-Cal has extended eligibility to individuals in optional categories, beyond those required by federal law. The four major Medi-Cal eligibility categories are:

- *Categorically Needy.* Includes families or individuals who receive cash assistance through CalWORKS, California's version of the federal Temporary Assistance for Needy Families (TANF), or Supplemental Security Income/State Supplementary Program (SSI/SSP) for aged, blind, or disabled individuals. CalWORKS and SSI/SSP beneficiaries automatically receive Medi-Cal eligibility cards and pay no part of their medical expenses for the covered services.
- *Medically Needy.* Includes certain families with dependent children and aged, blind, or disabled persons. Depending on their income level and household size, these individuals may have a "share of cost" or must first pay for a portion of their medical expenses ("spend down" to a certain level) before qualifying for aid. Medically Needy eligibles do not receive Public Assistance cash grants because they have too much income or resources.
- *Medically Indigent.* Includes low-income pregnant women and children under age 21, certain refugees, and certain individuals in long-term care facilities.
- *Newer Eligibles/Special Programs.* Includes a variety of eligibles such as undocumented persons and pregnant women and children who meet specific income criteria.

### Scope of Benefits

California's Medi-Cal Program has a broad scope of benefits compared to many other states. In all states, Medi-Cal covers a core of basic services required by federal law, including hospital inpatient and outpatient care, physician visits, laboratory tests and x-rays, family planning, regular examinations for children under age 21, and nursing home and home health care. In addition, California has exercised the option to cover additional services under Medi-Cal, covering 28 of 31 optional services such as prescription drugs, adult dental, durable medical equipment, chiropractic and podiatry services, and medical supplies.

### How Services Are Accessed

San Francisco is one of twelve California counties in which certain eligibles, including many children, youth, and families, must enroll in one of two managed care health plans available in the County. The two health plans available in San Francisco are Blue Cross of California and San Francisco Health Plan. Currently, about 33,500 Medi-Cal recipients are enrolled in managed care in San Francisco. Eligibles who enroll in a health plan choose a provider from a provider list from the plan. Medi-Cal eligibles who do not obtain services through a health plan choose their providers from those who

accept Medi-Cal (“fee-for-service”). In both “fee-for-service” and in health plans, public and private providers receive reimbursement for providing services to Medi-Cal beneficiaries.

### Number of Medi-Cal Eligibles

Throughout the nation, about 36 million people are covered by Medi-Cal, or approximately half of poor Americans. In 1996, San Francisco ranked 12th among 58 California counties in the total number of Medi-Cal eligibles, with 117,398 average monthly eligibles (about 5 million eligibles statewide). However, San Francisco ranked 32nd among California counties in the percentage of the population receiving Medi-Cal (15.3%) during the same year, slightly lower than the state average (16.6%).<sup>1</sup> Many more individuals could receive Medi-Cal but are often deterred from applying for benefits due to the complex eligibility process.

Age. In January 1997, there were about 40,000 Medi-Cal eligibles in San Francisco under age 21, accounting for about one-third (35%) of all Medi-Cal eligibles (113,826) in the City.<sup>2</sup> This proportion

Medi-Cal Eligibles, By Age Groups, San Francisco and California, January 1997				
Age Group	San Francisco		California	
	#	%	#	%
<1	3,082	3%	235,213	4%
1-5	12,125	11%	1,000,524	19%
6-10	9,563	8%	764,160	14%
11-15	7,985	7%	567,960	11%
16-20	7,129	6%	406,033	8%
<b>Subtotal, 0-20</b>	<b>39,884</b>	<b>35%</b>	<b>2,973,890</b>	<b>56.1%</b>
21+	73,942	65%	2,323,088	44%
<b>Total</b>	<b>113,826</b>	<b>100%</b>	<b>5,296,978</b>	<b>100%</b>
Source: California Department of Health Services, <u>Medi-Cal Eligibility By Zip Code Table</u> , January 1997				

is much lower than the state average of 56% of Medi-Cal eligibles who are under age 21. (Refer to the Appendix for detailed data.)

Aid Categories. Most children, youth, and families qualify for Medi-Cal through their eligibility for cash assistance under CalWORKS.<sup>3</sup> As of January 1997, 35,514 individuals, or 31% of all San

<sup>1</sup> California Department of Health Services, Medi-Cal Program, County Population, Medi-Cal Eligibles, and Medi-Cal Eligibles as a Percent of Population, Calendar Year 1996

<sup>2</sup> As of October 1996, there were 41,038 eligibles less than 21 years of age in San Francisco – also refer to the Appendix for detailed data.

<sup>3</sup> CalWORKS is California’s version of the federal Temporary Assistance to Needy Families (TANF) which replaced the Aid to Families with Dependent Children (AFDC) Program.

Francisco's Medi-Cal eligibles received Medi-Cal in conjunction with "Public Assistance CalWORKS" compared to the statewide average of 53%.<sup>4</sup> These individuals included both parent/guardian and dependent beneficiaries. In addition, there were over 10,000 Medi-Cal eligibles within the "Medically Needy CalWORKS" category which is designated for certain low-income families with children.

Many children and youth receive Medi-Cal under additional categories not linked to CalWORKS. In January 1997, these eligibles included over 4,000 youth receiving Medi-Cal under the "Medically Indigent Youth" category and over 3,000 children and youth receiving Medi-Cal under the 100 to 185% of Poverty categories.

<b>Medi-Cal Eligibles, By Aid Categories, San Francisco and California, January 1997</b>				
<u>Aid Category</u>	San Francisco		California	
	#	%	#	%
Public Assistance CalWORKS	35,514	31.0%	2,816,301	53.2%
Medically Needy CalWORKS	10,224	8.9%	434,544	8.2%
Medically Indigent Youth	4,106	3.6%	276,796	5.2%
100-200% of Poverty	3,412	3.0%	204,191	3.9%
Other Aid Categories	61,301	53.5%	1,565,182	29.5%
Total	114,557	100.0%	5,297,014	100.0%
Source: California Department of Health Services, <u>Medi-Cal Eligibility By Zip Code</u> , January 1997				

By Neighborhood. In January 1997, over half of San Francisco's Medi-Cal eligibles under age 21 resided within five City neighborhoods as defined by zip codes. The neighborhoods with the greatest number of Medi-Cal eligibles under age 21 were Inner Mission (5,734; 14.4% of total eligibles under age 21%), Bayview Hunters Point (5,616; 14.1%), Ingleside/Excelsior (4,070; 10.2%), Visitacion Valley (3,345; 8.4%), and Tenderloin/Civic Center (1,952; 4.9%). All these neighborhoods have a large number children and youth. (Refer to the Appendix for more detailed information.)

<sup>4</sup> There is a discrepancy between the total number of San Francisco Medi-Cal eligibles (114,557) in the table, "Medi-Cal Eligibles, By Aid Category, San Francisco and California, January 1997" and the total number of San Francisco Medi-Cal eligibles (113,826) in the table, "Medi-Cal Eligibles, By Age Groups, San Francisco and California, January 1997", with a difference of 731 eligibles or less than 0.7%. These differences were acknowledged by the data source (California Department of Health).

**Medi-Cal Eligibles,  
Ages 0-20, By Zip Code,  
San Francisco, January 1997**

<u>Zip Code</u>	<u>Neighborhood</u>	<u>#</u>	<u>%</u>
94110	Inner Mission	5,734	14.4%
94124	Bayview Hunters Point	5,616	14.1%
94112	Ingleside-Excelsior	4,070	10.2%
94134	Visitacion Valley	3,345	8.4%
94102	Tenderloin/Civic Center	1,952	4.9%
94115	Western Addition	1,864	4.7%
94109	Polk/Russian Hill	1,643	4.1%
94103	South of Market	1,562	3.9%
94121	Outer Richmond	1,483	3.7%
94122	Sunset	1,457	3.7%
-	Other	11,158	28.0%
	<b>TOTAL</b>	<b>39,884</b>	<b>100.0%</b>

Source: California Department of Health Services, Medi-Cal Eligibility By Zip Code, January 1997

Approximately 29% of San Francisco's residents under age 21 received Medi-Cal. However, the percentage of residents under age 21 receiving Medi-Cal within each neighborhood varies widely. Bayview Hunters Point is the top ranking neighborhood, with nearly 61% of the population under age 21 receiving Medi-Cal. Seven additional neighborhoods exceed the City's average of 29% of children and youth receiving Medi-Cal. These include South of Market (48.0%), Tenderloin/Civic Center (46.5%), Western Addition (45.2%), Rincon/Potrero Hill (45.1%), Visitacion Valley (32.2%), Inner Mission (31.4%), and Polk/Russian Hill (29.5%).

**Medi-Cal Eligibles As A Percent of Population,  
Ages 0-20, By Zip Code,  
San Francisco, January 1997**

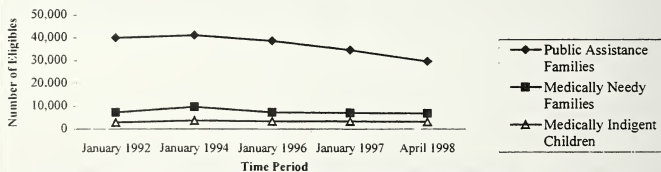
<u>Zip Code</u>	<u>Neighborhood</u>	Medi-Cal Eligibles	Population Ages 0-20	% of Pop'n On M-Cal
94124	Bayview-Hunter's Point	5,616	9,228	60.9%
94103	South of Market	1,562	3,254	48.0%
94102	Tenderloin/Civic Center	1,952	4,196	46.5%
94115	Western Addition	1,864	4,123	45.2%
94105/7	Rincon/Potrero Hill	1,057	2,346	45.1%
94134	Visitation Valley	3,345	10,375	32.2%
94110	Inner Mission	5,734	18,253	31.4%
94109	Polk/Russian Hill	1,643	5,577	29.5%
94104/11/33	Finan'l/Telegr'/N.Bch/C'town	1,289	4,703	27.4%
94112	Ingleside-Excelsior	4,070	16,638	24.5%
-	Other	11,752	60,002	19.6%
-	Total	39,884	138,695	28.8%

Source: California Department of Health Services, Medi-Cal Eligibility By Zip Code, January 1997

Note: Population based on 1990 Census.

**Trends.** From January 1992 to April 1998, the total number of Medi-Cal eligibles in San Francisco decreased 3.8% (from 103,316 to 99,404) compared to a 6.4% increase in the state as a whole. During

**Medi-Cal Eligibles, Selected Aid Categories,  
San Francisco, 1992-1998**



Source: California Department of Health Services, Persons Certified Eligible for Medi-Cal (1992-1998 reports)

the same time period, there was a dramatic decline (25.9%) in the number of San Francisco Medi-Cal eligibles under the Public Assistance CalWORKS category (from 41,061 to 29,703), in contrast to a

statewide decline of only 4.9%. The number of San Francisco Medi-Cal eligibles under the Medically Needy Families category dropped by only 5.8% (from 7,385 to 6,954), compared to a statewide increase of 47.3%. The number of San Francisco Medi-Cal eligibles under the Medically Indigent children category increased by 7.5% (from 3,007 to 3,232) compared to a statewide increase of 43.1%. (Refer to the Appendix for detailed data.)

## CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

The Child Health and Disability Prevention (CHDP) Program is a federally- and State-funded preventive health care program to make early health care available to eligible children. Eligible children include Medi-Cal beneficiaries ages 0 to 20, children of low-income families (with incomes less than 200% of the federal poverty level) ages 0 to 18, and children (generally ages 3 to 5) participating in Head Start or state preschool programs.

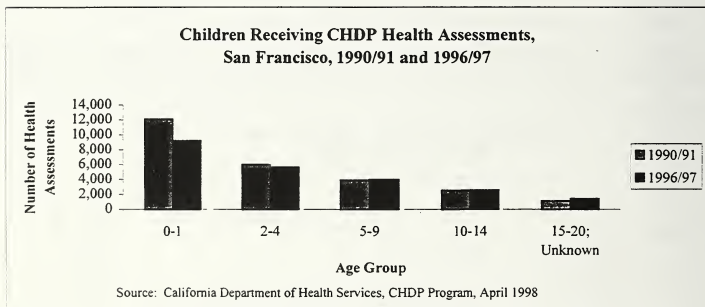
Each child is eligible to receive a periodic, comprehensive health assessment which includes a health and developmental history, physical examination, nutritional assessment, immunizations, vision and hearing testing, lead testing, laboratory tests, and health education and anticipatory guidance. CHDP health assessments are conducted by private and public physicians, clinics, and other providers. CHDP also provides annual preventive dental care for Medi-Cal eligible children ages 3 and over. Children with suspected problems are referred for necessary diagnosis and treatment.

### Target Population in San Francisco

Approximately 24% of San Francisco's CHDP target population (26,690 of 109,407) were served in 1996/97. This includes 25% of Medi-Cal beneficiaries younger than 21 years of age (16,000 or 64,764) and 24% of low-income children younger than 19 years of age (10,690 of 44,643). These percentages were slightly lower than the statewide averages for the same period (30% of total CHDP, 29% of Medi-Cal, and 30% of low-income target population served).<sup>1</sup>

### Demographics of Children and Youth Served

In 1996/97 (July 1 – June 30), a total of 22,919 San Francisco children and youth from birth to age 20 received at least one CHDP health assessment. This was 11% less than the number of children receiving health assessments in 1990/91 (25,671).



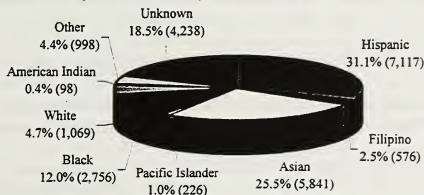
The largest proportion of children served in both 1990/91 and 1996/97 were in the birth to age 1 group (12,089 in 1990/91 and 9,219 in 1996/97). The number of children served decreased with age, with

<sup>1</sup> California Department of Health Services, Children's Medical Services, Child Health and Disability Prevention Program. Children Served By CHDP Compared to Target Populations, July 1996 through June 1997.

only 482 youth ages 15 to 20 receiving health assessments in 1996/97 (1,435 in 1990/91). (Refer to the Appendix for more detailed data.)

**By Race/Ethnicity.** In 1996/97, Hispanics comprised nearly one-third (31.1%) of children receiving CHDP health assessments, followed by Asians (25.5%) and Blacks (12.0%). Race/ethnic identifiers were unknown for 18.5% of children receiving health assessments.

**Children Receiving CHDP Health Assessments,  
By Race/Ethnicity, San Francisco, 1996/97**



Source: California Department of Health Services, CHDP Program, April 1998

#### **Children With Health Problems (Potential or Confirmed)**

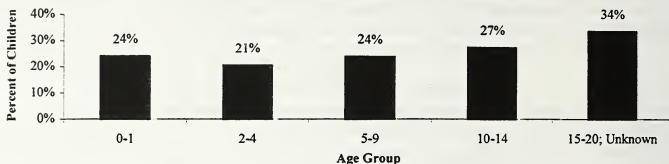
CHDP health assessments may result in identification of health problems, resulting in one of three possibilities:

- Treatment may be started for a problem with a confirmed diagnosis;
- A diagnosis may be pending and a return visit may be scheduled; or
- A referral may be made to another provider to confirm a diagnosis for the problem and/or to begin treatment.

In 1996/97, about one-quarter (24%) of San Francisco children receiving CHDP health assessments (5,530) were identified as having potential or confirmed health problems. The most common types of potential or confirmed health problems were related to dental (1,360 children), vision (572), nutrition (434), blood tests (366), and developmental (343).

**By Age.** A larger proportion (34%) of youth compared to younger children were found to have potential or confirmed health problems, although the number of health assessments in this age group

**Percent of Children with Potential or Confirmed Health Problems,  
By Age Group, San Francisco, 1996/97**

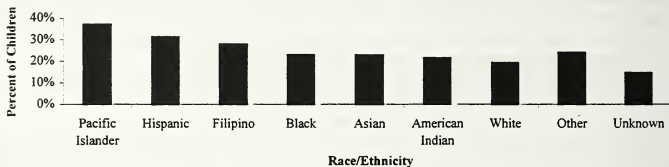


Source: California Department of Health Services, CHDP Program, April 1998

was less than for other age groups. Infants from birth to age 1 had the highest number of children identified with potential or confirmed health problems (2,217) compared to other age groups.

By Race/Ethnicity. In 1996/97, Pacific Islanders (37%), Hispanics (31%), and Filipinos (29%) were most likely among all racial/ethnic groups to have potential or confirmed health problems. Whites

**Percent of Children With Potential or Confirmed Health Problems,  
By Race/Ethnicity, San Francisco, 1996/97**



Source: California Department of Health Services, CHDP Program, April 1998

were the least likely (19%) to have potential or confirmed health problems compared to other children for whom race/ethnicity was identified.<sup>2</sup> A large proportion (24%) of children identified from "Other" race/ethnic groups had potential or confirmed health problems. (Refer to the Appendix for more detailed data.)

<sup>2</sup> These are the racial/ethnic categories designated by the CHDP Program.

## HEALTHY FAMILIES

The federal Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) to provide health insurance to children in low-wage, working families who would otherwise be uninsured. SCHIP will provide \$4 billion a year in federal funding over five years to states, including over \$850 million annually to California.

SCHIP is considered one of the most significant health system reform initiatives for children since the Medicaid program was enacted in 1965. The new federal law gave states wide latitude in designing their programs. States could expand their existing Medicaid programs (Medi-Cal in California), create new children's health insurance programs, or engage in some combination of the two strategies. California created a new insurance program called "Healthy Families" to use its share of these federal funds to cover low-income, uninsured children. Similar to Medi-Cal, Healthy Families is jointly financed by the federal and state funds, with the federal government expected to pay about two-thirds of California's program costs. In California, Healthy Families is administered by the Managed Risk Medical Insurance Board (MRMIB), an agency within the California Department of Health Services, and the program is overseen by the federal Health Care Financing Administration which also oversees the Medicaid (Medi-Cal) Program.

Throughout California, approximately 580,000 uninsured children are estimated to be eligible for Healthy Families, including an estimated 3,000 to 6,000 children in San Francisco. However, Healthy Families will not cover all uninsured children in California because some uninsured children are eligible for Medi-Cal, but are not enrolled; reside in families with household income over 200% of the federal poverty level; or are ineligible for Healthy Families due to their legal status (e.g., undocumented residents). Healthy Families began enrolling children in June 1998, for coverage beginning July 1, 1998. Since Healthy Families was only recently implemented, county-wide and statewide enrollment data is was not available for this report.

While the California legislature created Healthy Families as a program separate from Medi-Cal, it also made significant changes to Medi-Cal to help children and pregnant women. The Medi-Cal Program for adults, other than for pregnant women, remains unchanged. As of March 1998, more low-income children ages 14 to 18 qualify for Medi-Cal as a result of expanded eligibility rules. Under the new rules, both children and pregnant women are eligible based purely on income, regardless of property and assets, unlike traditional Medi-Cal rules. In addition, if a child loses Medi-Cal because family income rises, the child gets one additional month of Medi-Cal coverage. This is designed to give the family time to enroll the child in Healthy Families. Also under the new rules, children and pregnant women can use much shorter forms and apply for Medi-Cal through the mail, instead of using a very long form and an in-person interview as was previously required.

### Eligibility

To qualify for Healthy Families, children must be:

- Without private insurance.
- Ages 1 through 18.
- In a family with income at or below 200% of the federal poverty level (\$32,900 for a family of four) (income too high for no-cost Medi-Cal).

- Without any employer coverage during the last three months.
- U.S. citizens or legal immigrants who arrived in the U.S. before August 22, 1996, with some exceptions for certain groups such as refugees and asylees.

### **How Families Enroll; Eligible Service Plans**

Families can apply for Healthy Families through an application via mail or in-person with a certified “Application Assister.” Families choose from a list of eligible health, dental, and vision plans contracting with MRMIB. In San Francisco, these plans as of July 1, 1998 included:

- Health Plans: San Francisco Health Plan, Blue Cross HMO, Blue Shield HMO, Health Net, Kaiser Permanente;
- Dental Plans: DentiCare; Delta Dental;
- Vision Plan: Vision Services Plan.

### **Scope of Benefits**

Healthy Families provides comprehensive benefits equivalent to state employee health coverage, including physical and mental health, vision, and dental coverage. The benefits for all Healthy Families insurance plans are alike, with the exception of a few optional benefits such as acupuncture and chiropractic, which may vary between plans. Families cannot be denied coverage based on a child’s health condition. Children with serious physical disabilities can continue to receive specialized diagnostic, treatment, and case management services through California Children’s Services (CCS). Children with serious emotional problems can receive mental health services through county mental health departments.

### **Cost To Families**

To enroll their children, families must pay monthly premiums based on their income, family size, and the type of health plan chosen. In addition, families pay co-payments for certain services. The cost to enrollees is as follows:

- \$7 per month per child for families with incomes between 100 to 150% of poverty (\$16,450 - \$24,675 a year for a family of four). These families pay no more than \$14 per month for all their children.
- \$9 per month per child for families with incomes between 150 to 200% of poverty (\$24,675 to \$32,900 a year for a family of four). These families pay no more than \$27 per month for all their children.
- Families choosing a Community Provider Plan, the health plan in their region with the most safety net providers such as community clinics (in San Francisco - San Francisco Health Plan), get a monthly discount (up to \$3.00 per month per child).
- Families must pay \$5 co-payments whenever they seek health care (except for preventive services such as check-ups and shots), up to an annual maximum of \$250.
- Families who do not pay their premiums for two months or disenroll from the program are dropped from the program for six months, with certain exceptions.

### **How Services Are Accessed**

Children who are determined eligible for Healthy Families receive services through the health plan from providers who are on the provider list from the plan. In turn, public and private providers receive reimbursement from the plan for providing services to Healthy Families enrollees.

## GOLDEN GATE REGIONAL CENTER

Golden Gate Regional Center (GGRC) is a non-profit agency which provides a wide variety of services to individuals with developmental disabilities in order to help them become full participants in their communities. GGRC is under contract to the California State Department of Developmental Services to serve San Francisco, Marin, and San Mateo county residents.<sup>1</sup>

### Description of Services

GGRC is the County's main provider of assessment and case management services to people with developmental disabilities. GGRC's role is to identify client service needs and to facilitate linkages with other agencies so that clients receive needed services. GGRC is able to purchase services for clients that are not available from other publicly funded agencies. For example, GGRC is often the only source of funding for infant development programs, behavior management services, day treatment programs and transportation to day programs, out-of-home placement, and respite care and many clients go to GGRC specifically to obtain these services. Other services commonly required by clients include occupational, physical, and speech therapies and medical equipment. The type and number of services received by GGRC clients varies widely, depending on the client's age and condition.

### Eligibility Criteria

There are two sets of eligibility criteria for receiving services from GGRC, depending on the client's age. There are no financial eligibility requirements to receive services from GGRC - all income groups qualify.

- I. An individual over 3 years of age is eligible to receive services if he/she:
  - Is disabled due to mental retardation, Cerebral Palsy, epilepsy, autism, or other conditions requiring treatment similar to that required by mentally retarded persons,
  - Has had the disability prior to the age of 18,
  - Is likely to continue with the disability indefinitely,
  - Has a disability that is substantially handicapping.
- II. An individual under 3 years of age is eligible if he/she has a delay in development which is likely to lead to a developmental disability.

### Client Demographics

In July 1997, GGRC served a total of 743 San Francisco children and youth.<sup>2</sup>

By Age and Race/Ethnicity. Seventy-one percent (528) of GGRC clients were ages 3 to 18 and 29% (215) were up to 3 years old. Asians comprised 22% of clients, followed by Latino (18%), African-American (17%), and White (15%). Race/ethnicity was unknown for 28% of clients. The racial/ethnic mix differs within the two different age groups served by GGRC. African-Americans led the 0 to 36 months group (25%), followed by Latino (18%) and Asians (12%). In contrast, Asians led the 37

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<sup>1</sup> GGRC is one of 21 regional centers serving every county in the state. Since 1969, as a result of state legislation, regional centers were established to meet the needs of families of persons who were mentally retarded. Legislation passed in 1994 expanded the population served by regional centers to include individuals who are substantially handicapped by cerebral palsy, epilepsy or autism. This does not include all children and youth in San Francisco with developmental disabilities, and does not include former clients on "inactive" status with the agency.

<sup>2</sup> These include clients who were receiving services from GGRC and were on "active" status with the agency. GGRC also provides services to adults. All demographic data provided by GGRC.

months to 18 years group (27%), followed by Whites (19%) and Latinos (18%). (The reason for the differences in racial/ethnic mix is under review by GGRC staff and is not known at this time.)

**GOLDEN GATE REGIONAL CENTER CLIENTS,  
AGES 0-18, BY AGE GROUPS AND ZIP CODE,  
SAN FRANCISCO, AS OF JULY 31, 1997**

RACE/ETHNICITY	AGE GROUP					
	0-36 Months		37 Months -18 Years		TOTAL	
	#	%	#	%	#	%
Asian	25	12%	142	27%	167	22%
Latino	38	18%	97	18%	135	18%
African-American	53	25%	72	14%	125	17%
White	10	5%	102	19%	112	15%
Mixed/Other	21	10%	61	12%	82	11%
Filipino	9	4%	38	7%	47	6%
Pacific Islander	1	<1%	2	<1%	3	<1%
Native American	2	1%	0	0%	2	<1%
Unknown	56	26%	14	3%	70	9%
<b>TOTAL</b>	<b>215</b>	<b>100%</b>	<b>528</b>	<b>100%</b>	<b>743</b>	<b>100%</b>

Source: Golden Gate Regional Center, August 1997

**Primary Language and Neighborhood of Residence.** The primary languages spoken by GGRC clients include English (49%), followed by Spanish (14%), Chinese (11%), Vietnamese (2%), Tagalog (2%), Russian (1%), Cambodian (1%), and others (6%). Over half (52%) of clients came from five neighborhoods in the City, as defined by zip code, including Ingleside-Excelsior (113), Inner Mission (105), Bayview-Hunter's Point (65), Visitacion Valley (57), and Sunset (48). (Refer to the Appendix for more detailed data.)

**GOLDEN GATE REGIONAL CENTER CLIENTS,  
AGES 0-18, BY AGE GROUPS AND ZIP CODE,  
SAN FRANCISCO, AS OF JULY 31, 1997**

<u>Zip Code</u>	<u>Neighborhood</u>	0-36 Months	37 Months - 18 Years	TOTAL
94112	Ingleside-Excelsior	33	80	113
94110	Inner Mission	27	78	105
94124	Bayview Hunters Point	32	33	65
94134	Visitacion Valley	17	40	57
94122	Sunset	10	38	48
-	All Others	96	259	355
-	<b>TOTAL</b>	<b>215</b>	<b>528</b>	<b>743</b>

Source: Golden Gate Regional Center, August 1997

**Family Income.** The agency does not track family income of its clients, since family income is not considered in determining eligibility for services.

**Client Diagnoses.** A client's diagnosis is considered when determining eligibility for clients ages 37 months to 18 years. Among these clients, mental retardation is the most commonly occurring diagnosis, identified among 70% (371) of clients. A diagnosis of Cerebral Palsy occurs in 29% (156) of clients, followed by epilepsy/seizures (28% or 115), and autism (16% or 83). Forty percent of clients have more than one diagnosis identified.

**Duration of Services.**

Clients are enrolled with GGRC for varied periods of time, with some clients receiving services during their entire lifetime and others for less than a year. GGRC is required to serve all clients meeting the eligibility criteria with no time limits. The agency may not refuse to serve eligible clients for any reason.

## FAMILY PLANNING PROGRAM

The U.S. has one of the highest teen pregnancy rates among industrialized countries. Within our society, there has been ongoing controversy over how to respond to adolescents who are sexually active and need reproductive health services. Traditionally, low-income and underserved individuals have not had adequate access to comprehensive family planning services that including family planning education and counseling. In San Francisco, although utilization of subsidized family planning services has been increasing, only 20% of sexually active adolescent girls are estimated to access these services.<sup>1</sup>

The Family PACT (Planning, Access, Comprehensive Treatment Program previously “Family Planning Services”) seeks to provide services to low-income women and adolescents who may otherwise not be able to access family planning. For many clients, family planning services often become the initial access point into the medical care system. Medical problems may be initially identified by family planning providers who then make referrals to the appropriate providers for further diagnosis and treatment.

### Increased Access to Services

Beginning in March 1997, the availability of family planning services to low-income women and adolescents in San Francisco and throughout the state increased dramatically as a result of changes in California’s administration and funding of publicly supported family planning services. Midway through the 1996/97 program year, the State shifted responsibility for family planning services from a separate contractual program to the State’s Medi-Cal system. The new Family PACT program allows for a provider with a Medi-Cal license to become a designated family planning provider, and to be paid through the existing Medi-Cal billing process.<sup>2</sup>

This was a major change from the previous arrangement which limited the number of family planning providers available in each county, and capped family planning services at a set budget amount. Services are now entirely funded jointly by federal and state Medi-Cal funds, through a combination of grants and billed services. Also as part of this change, California raised the income threshold for clients eligible to receive services with incomes up to 200% of the federal poverty level (previously 150%). In San Francisco, the changes have resulted in the expansion of the number of public and private (non-profit and for-profit) family providers from four to 46, with many of these providers offering services at multiple sites.<sup>3</sup>

### Description of Services

Services provided under the Family PACT Program include physical exam (including breast exam and diagnosis of sexually transmitted diseases), lab tests, education and counseling, and choice of birth control method. Services are provided at no cost to clients, except for a voluntary \$5 co-pay per visit. Women and both male and female adolescents ages 12 to 19 who are up to 200% of poverty are

<sup>1</sup> San Francisco Department of Public Health, Family Planning Program; based on a formula used by Alan Guttmacher Institute (New York, New York) to estimate sexually active teens.

<sup>2</sup> Designation occurs through an application process, results in direct contracts between the state and local providers. Providers must agree to adhere to certain quality of care standards of practice, e.g., confidentiality of records and access to services.

<sup>3</sup> As of December 1997.

eligible to receive services. Clients must verify their income (through a self-declaration form) before receiving services.

### **Client Utilization**

In fiscal year 1995/96, the most recent period for which San Francisco data is available, the program provided a total of 19,108 visits, of which 16% (3,109) were visits by adolescents ages 12 and 19. Demographic information on clients served such as gender and location of residence, and clinical information such as diagnosis is not available.

Among the four participating agencies during 1995/96, the San Francisco Department of Public Health provided almost half (48%; 1,453) of all adolescent visits; University of California, San Francisco at San Francisco General Hospital (30%; 948); Planned Parenthood (12%; 387); and the Women's Needs Center (10; 321).<sup>4</sup>

Within less than a year of the statewide changes, preliminary estimates indicate a 33% increase in the number of clients served statewide by family planning providers, from 495,000 to 650,000.<sup>5</sup> Data on the number of clients served in San Francisco for the 1996/97 period is not currently available, although estimates are that the number served has increased significantly from the previous year.

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<sup>4</sup> 1996/97 utilization data provided by San Francisco Department of Public Health, Family Planning Program.

<sup>5</sup> Preliminary data provided by State Department of Health Services, Medi-Cal Division.

## SUMMARY

The Health and Well-Being of Children and Youth in San Francisco, 1998 report presents a broad range of health status indicators for children and youth in the City. In this section, we offer a few perspectives about the health and well-being of children and youth in San Francisco to help readers connect the wide variety of information presented in the report. Although the report is formatted with specific indicators presented as distinct sections, it is important for readers to consider children and youth more holistically, as complex and whole individuals, functioning within the context of their families, schools, and their communities.

### Poverty and Health

The leading health risk for children is a social condition rather than a disease or a particular physical or medical condition - it is poverty. This socio-economic condition contributes to poor nutrition, limits access to quality health care, and exposes children and youth to social and physical environments that are not conducive to good health.<sup>1</sup> Poverty is also closely linked to a number of undesirable outcomes related to education, emotional well-being, substance use, and crime. Families in poverty are under stress, and are not always able to adequately meet all the basic needs of children including food, shelter, medical care, emotional support, and adult guidance. Children in poverty with health problems may not have access to good medical care due to lack of insurance, parental working hours, transportation problems, or lack of money for medicine.

The relationship between poverty and poor health in children may be our most pressing social issue. We should continue to make available both public health and personal health services which address the health concerns and health needs of individuals and communities affected by poverty. However, we should also not lose sight of the need to advocate for the economic development of low-income communities and to work to eliminate the presence of health conditions rooted in poverty.

While the link between poverty and poor health is well-established through research, rarely does available health data available (including health status data presented in this report) also identify the socioeconomic conditions of individuals affected by the condition. From AIDS surveillance data to youth risk behavior data, the best we can usually do is to infer relative income level based on program eligibility rules for means-tested programs and from general neighborhood socioeconomic data.

### Health Issues by Age Group

This report alludes to how the stages of growth and development in children and youth affect the likelihood of different health problems. For purposes of identifying patterns of health problems which can be traced to various stages of growth and development, children and youth can be categorized within three broad age groups - infant through preschool (birth to age 4), young school-age (ages 5 to 10), and adolescence (roughly ages 11 to 19).

For children and youth as a whole, most do not have chronic health conditions, which are prevalent in the adult population. The development rate and physical, cognitive, and emotional change among children and youth exceeds that at any other stage of life, making them uniquely vulnerable to their

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<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA '95, DHHS Publication No. HRSA-M-DSEA-96-5, September 1996.

own set of social, environmental, and developmental risks.<sup>2</sup> Their health status is especially susceptible to the effects of social and economic factors such as environmental pollutants (e.g., lead), violence (e.g., injuries and arrests), substance use, and lack of access to health care services (e.g., immunization and dental care).

Reducing risks that affect the health of children and youth is possible. Unhealthy behaviors can be addressed by prevention strategies, which prevent health damaging behaviors and their short-term and long-term effects.<sup>3</sup> Health education and health promotion, preventive care, and early intervention should be dominant concerns of a health care system for children and youth, rather than the emphasis on acute episodic care and chronic disease management that are the focus for the adult system.

**Infants/Preschoolers.** Most health problems in infants and preschoolers from birth to age 4 are those affected by conditions related to birth as well as those conditions reflecting these very young children's extreme vulnerability and dependence on adult caregivers. For example, HIV infection rates and congenital anomalies are linked to factors in the prenatal period or may be related to genetics. The occurrence of unintentional injuries and the level of adherence to recommended immunization schedules are greatly dependent on the actions of and environments created by adult caregivers.

**Young School Age.** Young school age children ages 5 to 10 appear to have fewer identifiable health problems. While their independence is increasing, children of this age group continue to be dependent on adults to protect and promote their health and well-being. All children, but especially those in this age group, are learning from adults in their families and communities and are increasingly emulating behaviors they observe and the values promoted by adults. Children in this age group are becoming more socialized and are laying the foundation for more independent action. They are also beginning to become more vulnerable to peer pressure. In general, the lessons learned during this age period help to build the foundation which will affect what health behaviors these children will adopt when they become adolescents and adults.

**Adolescents.** Adolescence is a discrete life stage with unique and dramatic characteristics. Adolescents become less dependent on their parents and rely greatly on peer norms. Their health and well-being are greatly influenced by complex social and environmental contexts. These non-biological risk factors affecting health are unlikely to be resolved, or even addressed, in visits to medical clinicians. Instead, interventions may be most effective if designed within community settings where youth already go.<sup>4</sup> This report clearly illustrates that young people face some alarming health and safety risks at an early age. Significant levels of preventable death and illness are occurring including injuries due to violence, consequences of unprotected sexual behavior, and the negative impact of alcohol, tobacco, and other drug abuse; these can be linked to an increase in risk-taking behaviors by individuals in this age group.

### **African Americans**

This report also highlights a consistent disparity in the health and well-being of African American children and youth compared to children and youth of all other race/ethnicities. In many measures of

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<sup>2</sup> Stein, R.K., editor. Health Care for Children: What's Right, What's Wrong, What's Next. New York: United Hospital Fund, 1997.

<sup>3</sup> Ozer, E.M., Brindis, C.D., Millstein, S.G., Knopf, D.K., Irwin, C.E., Jr., America's Adolescents: Are they Healthy? National Adolescent Health Information Center, University of California at San Francisco, 1997.

<sup>4</sup> Stein, Ruth E.K., editor. Health Care for Children: What's Right, What's Wrong, What's Next. New York: United Hospital Fund, 1997.

health and well-being, ranging from school performance to foster care to specific health conditions, African American children and youth in San Francisco stand out as experiencing a disproportionate share of the problems identified in this report. African American children and youth are more likely to be poor than white children, and poverty is certainly linked to poor health status. However, children and youth from other racial/ethnic groups with high poverty levels do not do as poorly on many measures of health. Our challenge is to better understand and strategize ways to respond to the needs and conditions of the African American community, which appears to be in a health crisis in many ways.

### **Other At-Risk Groups**

While the glaring disparity between African Americans versus other groups cannot be overlooked, we also need to identify “hidden” pockets of individuals who may also be experiencing disproportionately poor health outcomes. These pockets may not be easily identifiable within the existing racial/ethnic categories or geographic units. For example, the data in this report show disparities between birth outcomes for Pacific Islander women compared to other subgroups within the “Asian/Pacific” category. Identifying specific subgroups like this can be useful in focusing resources on part of communities most in need.

### **Violence – Individuals and Communities**

The incidence of violence in the lives of children and youth in the City is a prominent result found in this report. The presence of both physical and psychological violence among individuals and within whole communities is reflected in the data on suicide, homicide and other violent crimes, intentional injuries, and in child abuse and neglect. Increasingly, children and youth are exposed to high levels of violence. A large number of children and youth are becoming witnesses to frequent violent behavior in their families and communities.

Research has shown that children exposed to violent incidents often suffer from a range of physical, social, educational, and emotional problems. Living in a context of violence makes social attachments more difficult for children and contributes to a sense of impending danger and a “live for today” attitude that limits the futures of these children. It is not surprising that children whose lives are bounded by violence have trouble concentrating in school, see little reason to work hard, and experience high failure rates.<sup>5</sup> Family violence harms not only its immediate victims, but touches us all by creating a breeding ground for violent behaviors. Individuals who are abused as children are more likely to be arrested for violent crime than those who have not been mistreated.<sup>6</sup>

The number of youth involved in the juvenile justice system and the nature of the offenses leading to arrests, as shown in this report, is very troubling, and has had an impact on the public health system of care. Historically, the major response to violence has been to enhance law enforcement. However, it is long overdue for violence to be viewed as a community health problem. In order to be effective, strategies should focus on addressing violent behavior at its roots. One challenge we face is for violence prevention to become a major component of both health and mental health services, with a broad range of agencies such as health, substance abuse, juvenile justice, education, and social services working together at the individual and community levels to address the epidemic.

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<sup>5</sup> Isaacs, M.R. *Violence: The Impact of Community Violence on African American Children and Families*. Arlington, VA: National Center for Education in Maternal and Child Health. 1992

<sup>6</sup> Wisdom, Cathy Spatz. “The Cycle of Violence”, Research in Brief 1, October 1992.

## **Risky Health Behaviors - Individuals and the Environment**

Behavior is intimately related to the environment. Without an environment which offers safe and productive ways to spend their free time, children and in particular youth, are more likely to be involved in criminal activity, drug and alcohol abuse, tobacco use, unsafe sexual activity, and other unhealthy behaviors which are discussed in this report. Our children and youth live in an environment in which they are bombarded by media images glamorizing illicit drugs, tobacco, the use of weapons, and early sexual activity. The environment also offers easy access to illicit or dangerous substances and promotes unhealthy eating habits. In general, our children and youth are overwhelmed by messages in their environment, which encourage behaviors leading to negative health consequences, and at the same time, provide limited possibilities for positive recreational and social interactions.

It is unrealistic to expect reductions in risky and unhealthful behaviors in children and youth without attempting to change both the environment and individual behaviors. We must vigorously pursue a two-pronged approach. First, we must work to change the environment, which promotes unhealthy behaviors. Second, we must recognize that some health problems do have significant behavioral components which we must work to influence in order to promote optimal health, well-being, and development.

## **Limitations of Data**

This report highlights the limitations of existing data in measuring the health and well-being of children and youth in our community. Data identifying the prevalence of many critical health conditions in children and youth, such as mental health problems, asthma, hunger, and poor nutritional status, may be unavailable or may not be available on a population-wide basis. Data to monitor health behaviors, from breastfeeding rates to use of illicit substances is even more limited or unavailable. We even lack good data to monitor poverty levels of both children and adults in San Francisco. In this report, we have included a limited number of program-based data sets which characterize the experience of specific groups of health care users. While this cannot completely substitute for city-wide, population-based data, it is often the best we have.

In addition, existing data fails to capture many important "quality of life" indicators that can reflect important elements of a healthy community. For example, data on the availability and use of quality after-school programs and safe outlets for recreation would be useful child and youth indicators. Other useful indicators could include the level of volunteerism by children, youth, and families and measures of family involvement in schools, churches, community groups, and civic activities; measures of parenting skills and knowledge; and the amount of quality time spent with children by parents or adult caregivers. A truly holistic report on the well-being of children and youth would systematically track the progress of many of these conditions which affect growth and development in children and youth, and the extent to which the City's children and youth have access to what they need in those areas.

Although this report often identifies a number of specific health problems experienced by individuals, it is usually difficult to know the extent to which those health problems are being disproportionately experienced by a relatively small group of individuals or whether they are more evenly dispersed among a larger part of the population. Being able to better pinpoint the affected population would allow for more effective planning and allocation of resources.

In addition, it is uncertain whether under-representation of certain racial/ethnic groups within the data presented in the report provides an accurate picture of health issues within those populations. Health problems may exist in certain populations, but the data does not identify those groups or some groups

may have less access to the services provided by programs generating the data. Also, as stated elsewhere in this report, data on a variety of health status measures may be available at the national level, but not at the county level which the report focuses on, and certainly not at the neighborhood level which we would like to monitor.

### **Conclusion**

The purpose of this report is to assess the health of children and youth in San Francisco by identifying key indicators of health status for children and youth. The data throughout the report points toward many deficits in the health status of the child and youth population. These deficits are revealed through health status indicators, each of which is one-dimensional and reflects a specific and limited aspect of the population under review.

This summary was meant to help readers take a more comprehensive view and to connect disparate and narrowly-defined indicators. The physical and social environment, our communities and families, individual behaviors, and access to and quality of care are, in fact, interrelated and in concert with each other have an impact on health. More importantly, this summary and the report as a whole are meant to be used as the evidence and motivation for readers to advocate for and develop policies and programs that promote comprehensive and connected interventions on behalf of San Francisco children and youth.

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- Population < By Age, San Francisco, 1990 Census
- 1998 Department of Health and Human Services Poverty Guidelines
- Department of Health and Human Services 1998 Annual Update of the HHS Poverty Guidelines
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- CalWORKS, Average Monthly Caseload, San Francisco, Year Ending June 30, 1985-1998
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- Recommended Childhood Immunization Schedule, United States, January – December 1998
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**Population, By Age Groups and Race/Ethnicity,  
San Francisco, 1990 and 1996 Estimates**

**1990**

**1996**

Age Group	Number					Number					
	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
<1					-	2,658	969	1,910	3,142	17	8,696
0-4	11,147	5,722	7,686	12,474	37,029	13,237	5,803	10,565	16,689	102	46,396
5-14	14,696	10,299	12,709	23,663	61,367	20,535	11,092	15,686	28,484	237	76,034
15-24	35,407	10,953	18,259	29,343	93,962	13,892	9,999	15,268	32,608	235	72,002
25-64	217,370	39,985	53,096	117,088	427,539	217,984	40,281	64,210	133,568	1,856	457,899
65+	59,234	9,577	8,961	26,231	104,003	56,377	9,988	12,236	37,072	259	115,932
All	337,854	76,536	100,711	208,799	723,900	322,025	77,163	117,965	248,421	2,689	768,263

Age Group	Percent of Sex & Ethnicity Group (Column %)					Percent of Sex & Ethnicity Group (Column %)					
	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
<1						0.8%	1.3%	1.6%	1.3%	0.6%	1.1%
0-4	3.3%	7.5%	7.6%	6.0%	5.1%	4.1%	7.5%	9.0%	6.7%	3.8%	6.0%
5-14	4.3%	13.5%	12.6%	11.3%	8.5%	6.4%	14.4%	13.3%	11.5%	8.8%	9.9%
15-24	10.5%	14.3%	18.1%	14.1%	13.0%	4.3%	13.0%	12.9%	13.1%	8.7%	9.4%
25-64	64.3%	52.2%	52.7%	56.1%	59.1%	67.7%	52.2%	54.4%	53.8%	69.0%	59.6%
65+	17.5%	12.5%	8.9%	12.6%	14.4%	17.5%	12.9%	10.4%	14.9%	9.6%	15.1%
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Age Group	Percent of Age Group (Row %)					Percent of Age Group (Row %)					
	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
<1						30.6%	11.1%	22.0%	36.1%	0.2%	100.0%
0-4	30.1%	15.5%	20.8%	33.7%	100.0%	28.5%	12.5%	22.8%	36.0%	0.2%	100.0%
5-14	23.9%	16.8%	20.7%	38.6%	100.0%	27.0%	14.6%	20.6%	37.5%	0.3%	100.0%
15-24	37.7%	11.7%	19.4%	31.2%	100.0%	19.3%	13.9%	21.2%	45.3%	0.3%	100.0%
25-64	50.8%	9.4%	12.4%	27.4%	100.0%	47.6%	8.8%	14.0%	29.2%	0.4%	100.0%
65+	57.0%	9.2%	8.6%	25.2%	100.0%	48.6%	8.6%	10.6%	32.0%	0.2%	100.0%
All	46.7%	10.6%	13.9%	28.8%	100.0%	41.9%	10.0%	15.4%	32.3%	0.4%	100.0%

Age Group	Percent of S.F. Population (Cell %)					Percent of S.F. Population (Cell %)					
	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
<1						0.3%	0.1%	0.2%	0.4%	0.0%	1.1%
0-4	1.5%	0.8%	1.1%	1.7%	5.1%	1.7%	0.8%	1.4%	2.2%	0.0%	6.0%
5-14	2.0%	1.4%	1.8%	3.3%	8.5%	2.7%	1.4%	2.0%	3.7%	0.0%	9.9%
15-24	4.9%	1.5%	2.5%	4.1%	13.0%	1.8%	1.3%	2.0%	4.2%	0.0%	9.4%
25-64	30.0%	5.5%	7.3%	16.2%	59.1%	28.4%	5.2%	8.4%	17.4%	0.2%	59.6%
65+	8.2%	1.3%	1.2%	3.6%	14.4%	7.3%	1.3%	1.6%	4.8%	0.0%	15.1%
All	46.7%	10.6%	13.9%	28.8%	100.0%	41.9%	10.0%	15.4%	32.3%	0.4%	100.0%

**Children & Youth Grouped Age Counts**

Age Group	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
<1	11,147	5,722	7,686	12,474	37,029	13,237	5,803	10,565	16,689	102	46,396
0-4	25,843	16,021	20,395	36,137	98,396	33,772	16,895	26,251	45,173	339	122,430
5-14	61,250	26,974	38,654	65,480	192,358	47,664	26,894	41,519	77,781	574	194,432

Age Group	Percent of Sex & Ethnicity Group (Column %)					Percent of Sex & Ethnicity Group (Column %)					
	White	Black	Hispanic	Asian/Oth	Total	White	Black	Hispanic	Asian	Am Ind	Total
0-4	3.3%	7.5%	7.6%	6.0%	5.1%	4.1%	7.5%	9.0%	6.7%	3.8%	6.0%
0-14	7.6%	20.9%	20.3%	17.3%	13.6%	10.5%	21.9%	22.3%	18.2%	12.6%	15.9%
0-24	18.1%	35.2%	38.4%	31.4%	26.6%	14.8%	34.9%	35.2%	31.3%	21.3%	25.3%

Sources:

- 1) California Department of Finance. 1993 Projections for 1990 data (based on and similar to but not exactly the same as 1990 Census data)
- 2) California Department of Finance. 1998 Revised Projections for 1996 data

10/7/98

**Population, By Selected Age Groups,  
By Age, Gender, and Race/Ethnicity,  
San Francisco, 1996 Estimates**

WHITE Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	1,347	1,311	2,658	0.8	0.8	0.8	30.3	30.8	30.6
0-4	6,834	6,403	13,237	4.2	4.0	4.1	28.9	28.2	28.5
5-14	10,478	10,057	20,535	6.4	6.3	6.4	27.1	27.0	27.0
15-19	3,503	3,321	6,824	2.1	2.1	2.1	20.2	20.1	20.2
20-24	3,520	3,548	7,068	2.2	2.2	2.2	17.9	19.1	18.5
25-44	72,021	64,973	136,994	44.2	40.9	42.5	48.4	46.3	47.3
45-64	44,131	36,859	80,990	27.1	23.2	25.2	51.6	44.4	48.1
65-74	12,370	14,017	26,387	7.6	8.8	8.2	45.3	41.5	43.2
75-84	7,856	13,126	20,982	4.8	8.3	6.5	52.0	54.3	53.4
84+	2,322	6,686	9,008	1.4	4.2	2.8	50.1	60.9	57.7
ALL	163,035	158,990	322,025	100.0	100.0	100.0	42.8	41.0	41.9

HISPANIC Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	1,003	907	1,910	1.7	1.6	1.6	22.6	21.3	22.0
0-4	5,353	5,212	10,565	9.0	8.9	9.0	22.6	22.9	22.8
5-14	7,949	7,737	15,686	13.3	13.3	13.3	20.5	20.7	20.6
15-19	3,505	3,403	6,908	5.9	5.8	5.9	20.3	20.6	20.4
20-24	4,390	3,970	8,360	7.4	6.8	7.1	22.4	21.4	21.9
25-44	24,216	20,432	44,648	40.6	35.0	37.8	16.3	14.5	15.4
45-64	9,578	9,984	19,562	16.1	17.1	16.6	11.2	12.0	11.6
65-74	2,753	3,784	6,537	4.6	6.5	5.5	10.1	11.2	10.7
75-84	1,299	2,552	3,851	2.2	4.4	3.3	8.6	10.6	9.8
84+	568	1,280	1,848	1.0	2.2	1.6	12.3	11.7	11.8
ALL	59,611	58,354	117,965	100.0	100.0	100.0	15.7	15.1	15.4

ASIAN/PI Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	1,620	1,522	3,142	1.4	1.2	1.3	36.4	35.8	36.1
0-4	8,529	8,160	16,689	7.1	6.3	6.7	36.0	35.9	36.0
5-14	14,622	13,862	28,484	12.2	10.8	11.5	37.7	37.2	37.5
15-19	7,618	7,172	14,790	6.4	5.6	6.0	44.0	43.5	43.8
20-24	9,220	8,598	17,818	7.7	6.7	7.2	46.9	46.3	46.6
25-44	39,534	41,819	81,353	33.0	32.5	32.7	26.5	29.8	28.1
45-64	24,265	27,950	52,215	20.3	21.7	21.0	28.3	33.7	31.0
65-74	9,778	12,550	22,328	8.2	9.8	9.0	35.8	37.2	36.6
75-84	4,708	6,291	10,999	3.9	4.9	4.4	31.1	26.0	28.0
84+	1,441	2,304	3,745	1.2	1.8	1.5	31.1	21.0	24.0
ALL	119,715	128,706	248,421	100.0	100.0	100.0	31.4	33.2	32.3

BLACK Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	469	500	969	1.3	1.2	1.3	10.5	11.8	11.1
0-4	2,905	2,898	5,803	7.8	7.2	7.5	12.3	12.7	12.5
5-14	5,564	5,528	11,092	15.0	13.8	14.4	14.4	14.8	14.6
15-19	2,620	2,536	5,156	7.1	6.3	6.7	15.1	15.4	15.3
20-24	2,445	2,398	4,843	6.6	6.0	6.3	12.4	12.9	12.7
25-44	12,518	12,678	25,196	33.7	31.7	32.7	8.4	9.0	8.7
45-64	7,274	7,811	15,085	19.6	19.5	19.5	8.5	9.4	9.0
65-74	2,304	3,341	5,645	6.2	8.3	7.3	8.4	9.9	9.2
75-84	1,220	2,153	3,373	3.3	5.4	4.4	8.1	8.9	8.6
84+	296	674	970	0.8	1.7	1.3	6.4	6.1	6.2
ALL	37,146	40,017	77,163	100.0	100.0	100.0	9.8	10.3	10.0

AM INDIAN Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	7	10	17	0.5	0.8	0.6	0.2	0.2	0.2
0-4	45	57	102	3.3	4.3	3.8	0.2	0.3	0.2
5-14	122	115	237	8.9	8.7	8.8	0.3	0.3	0.3
15-19	55	57	112	4.0	4.3	4.2	0.3	0.3	0.3
20-24	66	57	123	4.8	4.3	4.6	0.3	0.3	0.3
25-44	620	566	1,186	45.2	43.0	44.1	0.4	0.4	0.4
45-64	345	325	670	25.1	24.7	24.9	0.4	0.4	0.4
65-74	80	76	156	5.8	5.8	5.8	0.3	0.2	0.3
75-84	31	36	67	2.3	2.7	2.5	0.2	0.1	0.2
84+	9	27	36	0.7	2.1	1.3	0.2	0.2	0.2
ALL	1,373	1,316	2,689	100.0	100.0	100.0	0.4	0.3	0.4

TOTAL Age Group	Number			Ethnic-Sex Group %			Age-Sex Group %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(<1)	4,446	4,250	8,696	1.2	1.1	1.1	100.0	100.0	100.0
0-4	23,666	22,730	46,396	6.2	5.9	6.0	100.0	100.0	100.0
5-14	38,735	37,299	76,034	10.2	9.6	9.9	100.0	100.0	100.0
15-19	17,301	16,489	33,790	4.5	4.3	4.4	100.0	100.0	100.0
20-24	19,641	18,571	38,212	5.2	4.8	5.0	100.0	100.0	100.0
25-44	148,909	140,468	289,377	39.1	36.3	37.7	100.0	100.0	100.0
45-64	85,593	82,929	168,522	22.5	21.4	21.9	100.0	100.0	100.0
65-74	27,285	33,768	61,053	7.2	8.7	7.9	100.0	100.0	100.0
75-84	15,114	24,158	39,272	4.0	6.2	5.1	100.0	100.0	100.0
84+	4,636	10,971	15,607	1.2	2.8	2.0	100.0	100.0	100.0
ALL	380,880	387,383	768,263	100.0	100.0	100.0	100.0	100.0	100.0

Source: California Department of Finance, Race/Ethnic Population Estimates with Age and Sex Detail, 1970-1996, January 1998.  
obtained on-line at [www.dof.ca.gov/html/Demograp/race.html](http://www.dof.ca.gov/html/Demograp/race.html) (File Name: CO389096)

**SAN FRANCISCO POPULATION,  
BY ZIP CODE, ALL AGES AND AGES 0-17,  
1990 AND 1996**

Zip Code	Area	ALL AGES		AGES 0-17	
		1990	1996	1996	%
94102	Tenderloin/Hayes Val./N. of Market	26,908	29,050	4,489	15.5
94103	South of Market	17,867	18,443	2,810	15.2
94107	Potrero Hill	12,143	13,101	2,322	17.7
94108	Chinatown	14,143	15,157	1,785	11.8
94109	Polk/Russian Hill	49,585	52,628	5,516	10.5
94110	Inner Mission/Bernal Hts.	70,770	75,696	17,340	22.9
94111/04/05	Rincon/Tel. Hill/Embarcadero	5,897	6,932	400	5.8
94112	Ingleside-Exelsior/Crocker-Amazon	64,320	69,495	16,445	23.7
94114	Castro, Noe Valley	30,698	32,106	3,192	9.9
94115	Western Addition/Japantown	28,859	30,555	3,995	13.1
94116	Parkside	39,970	42,358	8,284	19.6
94117	Haight-Ashbury	38,063	39,888	5,043	12.6
94118	Inner Richmond	38,499	40,198	6,602	16.4
94121	Outer Richmond	40,430	42,786	7,305	17.1
94122	Sunset	52,318	55,483	9,952	17.9
94123	Marina	23,280	23,951	1,941	8.1
94124	Bayview-Hunter's Point	26,694	30,155	9,677	32.1
94127	St Francis Wood; Miraloma/Seaside	17,906	18,814	4,188	22.3
94131	Twin Peaks-Glen Park	30,585	31,941	5,073	15.9
94132	Lake Merced	23,632	24,646	4,474	18.2
94133	North Beach/Chinatown	26,959	28,143	3,923	13.9
94134	Visitacion Valley/Sunnydale	34,635	36,986	10,311	27.9
94129/30	Presidio & Treasure Island	9,224	9,689	3,423	35.3
All	TOTAL	723,385	768,202	138,488	18.0

Sources:

- 1) 1990 Census
- 2) CACI Marketing Systems, Sourcebook of Zip Code Demographics, 11th Edition, 1997 (see notes below)

Notes:

- 1) Data from this source is based on a population model run, and as such, is subject to various sources of error based on both the data and the assumptions used in the model. Because CACI's total population for San Francisco zip codes did not match the official state (California Department of Finance) population figures, the CACI estimates were controlled to the DOF total by straight ratio adjustment - that is, all zip code figures were multiplied by the ratio of the DOF April 1997 Interim Population Projections to CACI population totals (1.05217). Ages 0 to 17 figures were ratio-adjusted to San Francisco % < age 18 from 1993 California Department of Finance Population Projections (adjustment ratio = 1.1369). In addition, each estimated population figure by zip code (total or ages 0 to 17 estimate) was then rounded to the nearest 50 to remind readers of the imprecision inherent in generating the figure.
- 2) The 26 zip codes included above are considered residence-based zip codes. Excluded from this list are non-residence zip codes that are used either for institutions (e.g. University of California at San Francisco) or P.O. boxes.

**SAN FRANCISCO POPULATION,  
BY ZIP CODE, ALL AGES AND AGES 0-17,  
RANKED BY 1996 POPULATION AGES 0-17,  
1990 AND 1996**

Rank	Zip Code	Area	ALL AGES		AGES 0-17			
			1990	1996	1996	Row %	Col %	Cum. %
1	94110	Inner Mission/Bernal Hts.	70,770	75,696	17,340	22.9	12.5	12.5
2	94112	Ingleside-Excel'r/Crocker-Amazon	64,320	69,495	16,445	23.7	11.9	24.4
3	94134	Visitacion Valley/Sunnydale	34,635	36,986	10,311	27.9	7.4	31.8
4	94122	Sunset	52,318	55,483	9,952	17.9	7.2	39.0
5	94124	Bayview-Hunter's Point	26,694	30,155	9,677	32.1	7.0	46.0
6	94116	Parkside	39,970	42,358	8,284	19.6	6.0	52.0
7	94121	Outer Richmond	40,430	42,786	7,305	17.1	5.3	57.3
8	94118	Inner Richmond	38,499	40,198	6,602	16.4	4.8	62.0
9	94109	Polk/Russian Hill	49,585	52,628	5,516	10.5	4.0	66.0
10	94131	Twin Peaks-Glen Park	30,585	31,941	5,073	15.9	3.7	69.7
11	94117	Haight-Ashbury	38,063	39,888	5,043	12.6	3.6	73.3
12	94102	Tenderloin/Hayes Val./N. of Mkt.	26,908	29,050	4,489	15.5	3.2	76.6
13	94132	Lake Merced	23,632	24,646	4,474	18.2	3.2	79.8
14	94127	St. Fr' Wood; Miraloma/Seaside	17,906	18,814	4,188	22.3	3.0	82.8
15	94115	Western Addition/Japantown	28,859	30,555	3,995	13.1	2.9	85.7
16	94133	North Beach/Chinatown	26,959	28,143	3,923	13.9	2.8	88.5
17	94129/30	Presidio & Treasure Island	9,224	9,689	3,423	35.3	2.5	91.0
18	94114	Castro, Noe Valley	30,698	32,106	3,192	9.9	2.3	93.3
19	94103	South of Market	17,867	18,443	2,810	15.2	2.0	95.3
20	94107	Potrero Hill	12,143	13,101	2,322	17.7	1.7	97.0
21	94123	Marina	23,280	23,951	1,941	8.1	1.4	98.4
22	94108	Chinatown	14,143	15,157	1,785	11.8	1.3	99.7
23	94111/04/05	Rincon/Tel. Hill/Embarcadero	5,897	6,932	400	5.8	0.3	100.0
	All	TOTAL	723,385	768,202	138,488	18.0	100.0	-

Sources:

1) 1990 Census

2) CACI Marketing Systems, Sourcebook of Zip Code Demographics, 11th Edition, 1997 (see notes below)

Notes: Refer to table sorted by zip code - "San Francisco Population, By Zip Code, All Ages and Ages 0-17, 1990 and 1996."

**Population, By Age,  
San Francisco, 1990 Census**

<u>Age</u>	<u>#</u>	<u>%</u>
<1	6,258	0.9%
1-2	15,412	2.1%
3-4	13,600	1.9%
5	6,441	0.9%
6	6,305	0.9%
7-9	18,974	2.6%
10-11	11,870	1.6%
12-13	12,412	1.7%
14	5,914	0.8%
15	5,955	0.8%
16	6,546	0.9%
17	7,062	1.0%
18	7,230	1.0%
19	7,464	1.0%
20	8,938	1.2%
21	9,969	1.4%
22-24	37,594	5.2%
25-29	82,560	11.4%
30-34	77,959	10.8%
35-39	69,420	9.6%
40-44	60,993	8.4%
45-49	42,478	5.9%
50-54	35,269	4.9%
55-59	30,161	4.2%
60-61	12,110	1.7%
62-64	19,802	2.7%
65-69	32,079	4.4%
70-74	25,498	3.5%
75-79	20,735	2.9%
80-84	14,951	2.1%
85+	12,000	1.7%
Total	723,959	100.0%

Source: 1990 Census

**Administration On Aging****1998 DHHS Poverty Guidelines**

See related [AoA Information Memorandum](#) and [HHS Federal Register Notice](#) (html); also available in [PDF](#)

Poverty Guidelines			
Size of family unit	Contiguous (48) states and District of Columbia	Alaska	Hawaii
1	\$8,050	10,070	9,260
2	10,850	13,570	12,480
3	13,650	17,070	15,700
4	16,450	20,570	18,920
5	19,250	24,070	22,140
6	22,050	27,570	25,360
7	24,850	31,070	28,580
8	27,650	34,570	31,800

For family units with more than eight members, add the following amounts for each additional family member: \$2,800 (contiguous states and the District of Columbia); \$3,500 (Alaska); and \$3,220 (Hawaii). In each case, the same increment applies to smaller family sizes also, as can be seen in the figures above.

The information in this table was originally published in the *Federal Register*, February 24, 1998, (Volume 63, Number 36)] [Notices] [Page 9235-9238].

Table compiled by the U.S. Administration on Aging.

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Hypertext conversion by [Saadia Greenberg](#)

— last modified 03/02/98 09:22:47



## DEPARTMENT OF HEALTH & HUMAN SERVICES



### DEPARTMENT OF HEALTH AND HUMAN SERVICES 1998 Annual Update of the HHS Poverty Guidelines

(also available in PDF format; requires use of Adobe Acrobat Reader -- free)

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[Federal Register: February 24, 1998 (Volume 63, Number 36)] [Notices]

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice

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**SUMMARY:** This notice provides an update of the HHS poverty guidelines to account for last (calendar) year's increase in prices as measured by the Consumer Price Index.

**EFFECTIVE DATE:** These guidelines go into effect on the day they are published (unless an office administering a program using the guidelines specifies a different effective date for that particular program).

**ADDRESSES:** Office of the Assistant Secretary for Planning and Evaluation, Room 438F, Humphrey Building, Department of Health and Human Services (HHS), Washington, D.C. 20201.

**FOR FURTHER INFORMATION CONTACT:** *For information about how the poverty guidelines are used in a particular program*, contact the Federal (or other) office which is responsible for that program.

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For general information about the poverty guidelines (but NOT for information about a particular program--such as the Hill-Burton Uncompensated Services Program--that uses the poverty guidelines), contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 438F, Humphrey Building, Department of Health and Human Services, Washington, D.C. 20201--telephone: (202) 690-6141.

*For information about the Hill-Burton Uncompensated Services Program* (no-fee or reduced-fee health care services at certain hospitals and other health care facilities for certain persons unable to pay for such care), contact the Office of the Director, Division of Facilities Compliance and Recovery, HRSA, HHS, Twinbrook Metro Plaza, 12300 Twinbrook Parkway, Suite 520, Rockville, Maryland 20852-- telephone: (301) 443-5656 or 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

Under an amendment to the Older Americans Act, the figures in this notice are the figures that state and area agencies on aging should use to determine "greatest economic need" for Older Americans Act programs. For information about Older Americans Act programs, contact Carol Crecy, Administration

on Aging, HHS--telephone: (202) 619-0011.

*For information about the Department of Labor's Lower Living Standard Income Level (an alternative eligibility criterion with the poverty guidelines for certain Job Training Partnership Act programs), contact Theodore W. Mastroianni, Associate Assistant Secretary, Employment and Training Administration, U.S. Department of Labor-- telephone: (202) 219-6236.*

*For information about the number of persons in poverty (since 1959) or about the Census Bureau (statistical) poverty thresholds, contact the HHES Division, Room 1462, Federal Office Building #3, U.S. Bureau of the Census, Washington, D.C. 20233--telephone: (301) 457-3242.1998*

### **Poverty Guidelines for the 48 Contiguous States and the District of Columbia**

#### **Size of family unit ..... Poverty guideline**

---

1.....	\$8,050
2.....	10,850
3.....	13,650
4.....	16,450
5.....	19,250
6.....	22,050
7.....	24,850
8.....	27,650

---

For family units with more than 8 members, add \$2,800 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

### **1998 Poverty Guidelines for Alaska**

#### **Size of family unit ..... Poverty guideline**

---

1.....	\$10,070
2.....	13,570
3.....	17,070
4.....	20,570
5.....	24,070
6.....	27,570
7.....	31,070
8.....	34,570

---

For family units with more than 8 members, add \$3,500 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

### **1998 Poverty Guidelines for Hawaii**

#### **Size of family unit ..... Poverty guideline**

---

1.....	\$9,260
2.....	12,480
3.....	15,700
4.....	18,920
5.....	22,140
6.....	25,360
7.....	28,580
8.....	31,800

---

For family units with more than 8 members, add \$3,220 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

(Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the Census Bureau poverty thresholds--the primary version of the poverty measure--have never had separate figures for Alaska and Hawaii.

The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and- D.C. guidelines for those jurisdictions or to follow some other procedure.)

The preceding figures are the 1998 update of the poverty guidelines required by section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97-35). As required by law, this update reflects last year's change in the Consumer Price Index (CPI-U); it was done using the same procedure used in previous years.

Section 673(2) of OBRA-1981 (42 U.S.C. 9902(2)) requires the use of the poverty guidelines as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines are also used as an eligibility criterion by a number of other Federal programs (both HHS and non-HHS). Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services (formerly by the Office of Economic Opportunity/Community Services Administration). The poverty guidelines may be formally referenced as "the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of section 673(2) of the Omnibus Budget Reconciliation Act of 1981."

The poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. The poverty guidelines issued by the Department of Health and Human Services are used for administrative purposes--for instance, for determining whether a person or family is financially eligible for assistance or services under a particular Federal program. The poverty thresholds are used primarily for statistical purposes. Since the poverty

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guidelines in this notice--the 1998 guidelines--reflect price changes through calendar year 1997, they are approximately equal to the poverty thresholds for calendar year 1997 which the Census Bureau will issue in late summer or autumn 1998. (A preliminary version of the 1997 thresholds is now available from the Census Bureau.)

In certain cases, as noted in the relevant authorizing legislation or program regulations, a program uses the poverty guidelines as only one of several eligibility criteria, or uses a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines). Non-Federal organizations which use the poverty guidelines under their own authority in non-Federally-funded activities also have the option of choosing to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

Some programs, while not using the guidelines to exclude non-lower-income persons as ineligible, use them for the purpose of giving priority to lower-income persons or families in the provision of assistance or services. In some cases, these poverty guidelines may not become effective for a particular program until a regulation or notice specifically applying to the program in question has been issued.

The poverty guidelines given above should be used for both farm and nonfarm families. Similarly, these guidelines should be used for both aged and non-aged units. The poverty guidelines have never had an aged/ non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures

for aged and non-aged one-person and two-person units.

### Definitions

There is no universal administrative definition of "income," "family," "family unit," or "household" that is valid for all programs that use the poverty guidelines. Federal programs may use administrative definitions that differ somewhat from the statistical definitions given below; the Federal office which administers a program has the responsibility for making decisions about administrative definitions. Similarly, non-Federal organizations which use the poverty guidelines in non-Federally-funded activities may use administrative definitions that differ from the statistical definitions given below. In either case, to find out the precise definitions used by a particular program, one must consult the office or organization administering the program in question.

The following statistical definitions (derived for the most part from language used in U.S. Bureau of the Census, Current Population Reports, Series P60-185 and earlier reports in the same series) are made available for illustrative purposes only; in other words, these statistical definitions are not binding for administrative purposes.

(a) Family. A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment, they would all be considered members of a single family.

(b) Unrelated individual. An unrelated individual is a person 15 years old or over (other than an inmate of an institution) who is not living with any relatives. An unrelated individual may be the only person living in a house or apartment, or may be living in a house or apartment (or in group quarters such as a rooming house) in which one or more persons also live who are not related to the individual in question by birth, marriage, or adoption. Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

(c) Household. As defined by the Bureau of the Census for statistical purposes, a household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units (see next item), but only one household. Some programs, such as the food stamp program and the Low-Income Home Energy Assistance Program, employ administrative variations of the "household" concept in determining income eligibility. A number of other programs use administrative variations of the "family" concept in determining income eligibility. Depending on the precise program definition used, programs using a "family" concept would generally apply the poverty guidelines separately to each family and/or unrelated individual within a household if the household includes more than one family and/or unrelated individual.

(d) Family unit. "Family unit" is not an official U.S. Bureau of the Census term, although it has been used in the poverty guidelines Federal Register notice since 1978. As used here, either an unrelated individual or a family (as defined above) constitutes a family unit. In other words, a family unit of size one is an unrelated individual, while a family unit of two/three/etc. is the same as a family of two/three/etc.

(e) Income. Programs which use the poverty guidelines in determining eligibility may use administrative definitions of "income" (or "countable income") which differ from the statistical definition given below. Note that for administrative purposes, in many cases, income data for a part of a year may be annualized in order to determine eligibility—for instance, by multiplying by four the amount of income received during the most recent three months.

For statistical purposes—to determine official income and poverty statistics—the Bureau of the Census defines income to include total annual cash receipts before taxes from all sources, with the exceptions noted below. Income includes money wages and salaries before any deductions; net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses); net receipts from farm

self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses); regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, and non-Federally-funded General Assistance or General Relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

For official statistical purposes, income does not include the following types of money received: capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car; or tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury. Also excluded are noncash benefits, such as the employer-paid or

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union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, and such Federal noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance.

Dated: February 17, 1998.

**Donna E. Shalala,**  
*Secretary of Health and Human Services.*  
[FR Doc. 98-4566 Filed 2-20-98; 8:45 am]  
BILLING CODE 4150-04-M

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Hypertext conversion by [Saadia Greenberg](#), February 25, 1998

**Unemployment Rates,  
By Age Groups,  
San Francisco and California, 1990-1997**

	Year							
	1990	1991	1992	1993	1994	1995	1996	1997
San Francisco, All Ages	3.8%	5.4%	6.9%	7.0%	6.4%	6.1%	4.7%	4.0%
California, Ages 16-19	15.6%	20.1%	25.1%	26.2%	22.8%	22.6%	23.1%	20.6%
California, All Ages	5.6%	7.5%	9.1%	9.2%	8.6%	7.8%	7.2%	6.3%

Source: U.S. Department of Labor, Bureau of Labor Statistics; Current Population Survey (Provided by State of California, Employment Development Department, Unemployment Rates for Labor Force Groups in California By Sex/Age; Civilian Labor Force, Employment, and Unemployment, San Francisco County), obtained on-line at [www.calmis.cahwnet.gov](http://www.calmis.cahwnet.gov) on May 15, 1998.

Notes:

- 1) The "unemployment rate"(also referred to as the "civilian unemployment rate") is the number of unemployed people as a percentage of the labor force. Unemployed people includes individuals ages 16 and over who are not working but are able, available, and looking for work and excludes individuals in the military or those who are institutionalized such as in prisons and in mental or physical health facilities.
- 2) Both San Francisco and California rates are annual average unemployment rates. Monthly rates are 12-month moving averages; the rates for December of each year provide the annual average for the year.
- 3) State and county data shown above are not seasonally adjusted.
- 4) County level data for ages 16 to 19 is not available.

**CalWORKS,\*\***  
**Average Monthly Caseload,**  
**San Francisco,**  
**Year Ending June 30, 1985-1998**

<u>Year Ending</u> <u>June 30</u>	<u>Cases</u>	
	<u>#</u>	<u>% Change</u>
1998*	8,452	-15.4%
1997*	9,987	-11.2%
1996*	11,252	-9.8%
1995	12,469	-4.8%
1994	13,091	2.4%
1993	12,780	2.5%
1992	12,464	2.5%
1991	12,157	5.8%
1990	11,491	3.2%
1989	11,130	-2.1%
1988	11,369	-3.3%
1987	11,761	-2.6%
1986	12,079	-3.7%
1985	12,544	-

Sources:

- 1) San Francisco Department of Social Services, 1993/94 Annual Report (for 1985-1994)
- 2) San Francisco Department of Social Services, 1994/95 Annual Report, (for 1995)
- 3) San Francisco Department of Social Services, San Francisco Caseload Demographics, September 1996 (for 1996)
- 4) San Francisco Department of Human Services, San Francisco TANF Snapshot Quarterly Report: All Households, January 1998 (for 1997)
- 5) San Francisco Department of Human Services, Neighborhood Breakdown of CalWORKS Caseload, April 1998 Caseload Data (for 1998)

Notes:

- \*1) 1996 cases are for September 1996 only; 1997 cases are for May 1997 only; 1998 cases are for April 1998 only.
- \*\*2) Previously Aid To Families With Dependent Children (AFDC).

**CalWORKS,\***  
**Family Groups and Unemployed Parent Combined Cases,**  
**Recipients and Children,**  
**California,**  
**Year Ending June 30, 1980 to 1997**

<u>Year Ending</u> <u>June 30</u>	Average Monthly Cases/Recipients					
	Cases		Recipients		Children	
	#	% Change	#	% Change	#	% Change
1997	842,616	-6.7%	2,478,292	-6.3%	1,716,787	-5.5%
1996	902,813	-2.0%	2,645,813	-1.3%	1,815,896	-0.9%
1995	921,011	2.5%	2,679,517	2.9%	1,832,105	2.8%
1994	898,378	6.4%	2,603,104	7.8%	1,781,873	6.2%
1993	844,393	6.8%	2,414,729	6.6%	1,677,251	6.8%
1992	790,406	11.9%	2,266,262	10.6%	1,569,837	11.8%
1991	706,510	11.0%	2,048,430	10.3%	1,404,271	11.5%
1990	636,255	6.3%	1,856,691	6.3%	1,259,330	7.3%
1989	598,780	2.3%	1,747,028	2.1%	1,173,187	2.2%
1988	585,243	0.7%	1,711,289	1.3%	1,147,967	1.2%
1987	581,253	3.7%	1,689,987	3.3%	1,133,992	4.1%
1986	560,727	2.1%	1,636,047	1.6%	1,089,780	2.7%
1985	549,183	0.5%	1,609,951	0.3%	1,060,677	1.4%
1984	546,719	2.9%	1,605,577	2.8%	1,046,360	3.4%
1983	531,186	3.1%	1,561,558	1.8%	1,011,509	0.9%
1982	515,405	3.0%	1,533,458	3.0%	1,002,821	1.9%
1981	500,327	9.1%	1,488,935	9.8%	984,530	8.2%
1980	458,801	0.0%	1,355,727	-0.6%	909,808	-1.1%

Source: California Department of Social Services, Statewide Summaries, October 1997  
(www.dss.cahwnet.gov)

Notes:

- 1) "Recipients" includes children.  
\* 2) Previously Aid To Families With Dependent Children (AFDC).

**CalWORKS,  
Number of Children and Caregivers By Age Groups,  
San Francisco, May 1997**

<u>Children/Age Groups</u>	<u>#</u>	<u>%</u>
0-1	1,934	10.8%
2-5	4,671	26.0%
6-12	6,929	38.6%
13-15	2,621	14.6%
16-19	1,782	9.9%
Total Children	17,937	100.0%

<u>Caregivers/Age Groups</u>	<u>#</u>	<u>%</u>
13-15	0	0.0%
16-19	299	3.1%
20-29	2,667	27.2%
30-39	3,460	35.3%
40-49	2,663	27.2%
50-59	622	6.4%
60+	79	0.8%
Total Adult Caregivers	9,790	100.0%
Total, Children and Caregivers	27,727	

Source: San Francisco Department of Human Services, San Francisco TANF  
Snapshot Quarterly Report: All Households, September 1996-January 1998

**CalWORKS,  
Number of Cases By Family Size,  
San Francisco, May 1997**

<u>Family Size</u>	<u>#</u>	<u>%</u>
Families w/ 1 Child, Unborn	198	2.0%
Families w/ 1 Child	4,869	49.0%
Families w/ 2 Children	2,827	28.4%
Families w/ 3 Children	1,286	12.9%
Families w/ 4 Children	497	5.0%
Families w/ 5 Children	168	1.7%
Families w/ 6 Children	63	0.6%
Families w/ 7+ Children	34	0.3%
Total Families	9,942	100.0%

Source: San Francisco Department of Human Services,  
San Francisco TANF Snapshot Quarterly Report: All  
Households, September 1996-January 1998

**CalWORKs,  
Number of Cases By Zip Code (Sorted),  
San Francisco, May 1997**

<u>Zip Code</u>	<u>Neighborhood</u>	<u>Cases</u>	
		<u>#</u>	<u>%</u>
94124	Bayview/Hunters Point	1,755	17.6%
94110	Mission	1,181	11.8%
94134	Visitation Valley	945	9.5%
94112	Ingelside/Excelsior	896	9.0%
94102	Tenderloin	622	6.2%
94115	Western Addition	592	5.9%
94121	Outer Richmond	481	4.8%
94122	Sunset	424	4.2%
94109	Polk Gulch	412	4.1%
94107	Potrero Hill	391	3.9%
94103	South of Market	382	3.8%
94118	Inner Richmond	316	3.2%
94117	Haight/Lower W. Add'n	302	3.0%
94133	North Beach	283	2.8%
94116	Parkside	275	2.8%
94132	Lake Merced	213	2.1%
94131	Glen Park	114	1.1%
94108	Chinatown	74	0.7%
94114	Eureka Valley	48	0.5%
94127	Miraloma	46	0.5%
-	Homeless	114	1.1%
-	Other/Unknown	121	1.2%
TOTAL		9,987	100.0%

Source: San Francisco Department of Human Services, San Francisco TANF Snapshot Quarterly Report: All Households, September 1996-January 1998

**San Francisco Unified School District,  
Enrollment Data, By Ethnicity and Limited English Status,  
(Sorted By Enrollment By Zip Code), 1996/97**

Zip Code	Area	Ethnicity					TOTAL		Limited English			
		Chinese	Latino	Afr-Am	White	Other	Filipino	#	%	Limited #	Non #	Total %
94112	Ingleside-Excelsior	1,726	2,796	825	610	583	1,559	8,170	13.3%	2,502	439	36.0%
94110	Inner Mission	500	5,081	501	739	520	462	7,876	12.8%	3,160	551	47.1%
94124	Bayview-Hunter's Point	635	755	3,579	179	832	187	6,287	10.2%	832	118	15.1%
94134	Visitacion Valley-Portola	1,431	975	1,180	207	648	692	5,181	8.4%	1,423	216	31.6%
94122	Sunset	2,270	199	110	1,035	656	203	4,677	7.6%	1,045	184	26.3%
94121	Outer Richmond	2,058	171	140	1,119	645	110	4,554	7.4%	938	142	23.7%
94116	Parkside	2,064	221	83	735	581	141	4,003	6.5%	928	154	27.0%
94118	Inner Richmond	1,118	102	95	544	435	60	2,505	4.1%	621	100	28.8%
94109	Polk Gulch-Russian Hill	1,075	250	70	206	430	82	2,168	3.5%	918	196	51.4%
94133	North Beach/Chinatown	1,670	64	88	81	162	16	2,093	3.4%	943	191	54.2%
94102	Tenderloin-Western Addition	309	322	470	203	481	156	1,975	3.2%	678	114	40.1%
94115	Western Addition-Pac Hts	142	120	1,131	174	250	59	1,927	3.1%	222	29	13.0%
94132	Lake Merced	362	173	485	309	212	94	1,763	2.9%	283	45	18.6%
94103	South of Market	71	746	124	82	212	368	1,619	2.6%	682	124	49.8%
94117	H'ght Ashby-Lwr W'n Add'n	59	148	561	355	138	43	1,341	2.2%	139	29	12.5%
94131	Twin Peaks-Glen Park	142	284	195	358	138	73	1,233	2.0%	110	24	10.9%
94127	Miraloma-Sunnyside	251	99	89	354	125	50	1,036	1.7%	104	19	11.9%
94107	Potrero Hill	45	129	468	122	119	41	944	1.5%	99	17	12.3%
94108	Chinatown	790	24	9	32	57	28	943	1.5%	503	120	66.1%
94114	Eureka Valley	23	135	40	298	57	22	602	1.0%	51	4	9.1%
94123	Marina-Cow Hollow	48	12	11	130	21	3	234	0.4%	33	7	17.1%
94129	Presidio	0	8	55	101	17	10	196	0.3%	1	-	0.5%
Other*	Other	56	12	33	35	10	28	176	0.0	39	7	26.1%
	TOTAL*	16,845	12,826	10,342	8,008	8,594	4,487	61,503	100.0%	16,254	2,830	31.0%
	Percent	27.6%	21.0%	16.9%	13.1%	14.1%	7.3%	100.0%		26.4%	4.6%	

sfstdzip.xls, Sheet2  
6/30/98

Source: San Francisco Unified School District

\*Note: Other zip's with < 100 students not included in totals.

**Dropout Rates,  
San Francisco Unified School District,  
By Race/Ethnicity,  
San Francisco, 1997/98**

<u>Race/Ethnicity</u>	<u># of Students</u>	<u>% of Race/ Ethnic Group</u>	<u>% of Dropouts</u>
African American	543	5.5%	25.9%
Latino	592	4.6%	28.2%
American Indian	17	4.1%	0.8%
Filipino	164	3.7%	7.8%
White	262	3.5%	12.5%
Other Non-White	230	3.1%	11.0%
Chinese	279	1.6%	13.3%
Japanese	8	1.4%	0.4%
Korean	4	0.6%	0.2%
Total	2,099	3.0%	100.0%

Source: San Francisco Unified School District, Final Dropout Report  
1997/98, July 20, 1998

**LIVE BIRTHS,  
BY MOTHER'S AGE GROUP,  
SAN FRANCISCO RESIDENTS,  
1991-1995**

AGE	1991		1992		1993		1994		1995		1996	
	#	%	#	%	#	%	#	%	#	%	#	%
12-15	74	0.7%	76	0.8%	66	0.7%	68	0.8%	60	0.7%	53	0.6%
16-17	256	2.6%	213	2.2%	237	2.6%	210	2.3%	210	2.4%	181	2.2%
18-19	501	5.1%	432	4.5%	397	4.3%	408	4.5%	385	4.5%	373	4.5%
20-34	7,239	73.2%	7,045	73.6%	6,793	73.3%	6,553	72.4%	6,108	71.1%	6,002	71.7%
35+	1,823	18.4%	1,799	18.8%	1,775	19.2%	1,806	20.0%	1,830	21.3%	1,757	21.0%
Unknown	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.0%
TOTAL	9,893	100.0%	9,566	100.0%	9,268	100.0%	9,045	100.0%	8,593	100.0%	8,368	100.0%

Source: San Francisco County AVSS Birth Records

LIVE BIRTHS,  
BY MOTHER'S RACE/ETHNICITY,  
SAN FRANCISCO RESIDENTS,  
1991-1996

RACE/ETHNICITY	1991		1992		1993		1994		1995		1996	
	#	%	#	%	#	%	#	%	#	%	#	%
White	2,806	28.4%	2,599	27.2%	2,624	28.3%	2,555	28.2%	2,619	30.5%	2,587	30.9%
Latina	2,231	22.6%	2,237	23.4%	2,154	23.2%	2,056	22.7%	1,904	22.2%	1,884	22.5%
Chinese	1,869	18.9%	1,952	20.4%	1,805	19.5%	1,934	21.4%	1,710	19.9%	1,755	21.0%
Black	1,425	14.4%	1,281	13.4%	1,242	13.4%	1,125	12.4%	1,018	11.8%	883	10.6%
Filipina	761	7.7%	675	7.1%	662	7.1%	638	7.1%	644	7.5%	622	7.4%
Other Asian	514	5.2%	510	5.3%	505	5.4%	451	5.0%	481	5.6%	427	5.1%
Pacific Islander	103	1.0%	86	0.9%	116	1.3%	110	1.2%	94	1.1%	87	1.0%
Other	143	1.4%	195	2.0%	148	1.6%	166	1.8%	95	1.1%	96	1.1%
Unknown	41	0.4%	31	0.3%	12	0.1%	10	0.1%	28	0.3%	27	0.3%
TOTAL	9,893	100.0%	9,566	100.0%	9,268	100.0%	9,045	100.0%	8,593	100.0%	8,368	100.0%

Source: San Francisco County AVSS Birth Records

**TABLE 1a: 1996 SAN FRANCISCO RESIDENT LIVE BIRTHS  
BY MOTHER'S ETHNICITY AND AGE GROUP**

ETHNICITY	AGE GROUP					Total
	12-15	16-17	18-19	20-34	35+	
WHITE	3	13	36	1743	792	2,587
	0.1%	0.5%	1.4%	67.4%	30.6%	30.9%
	5.7%	7.2%	9.7%	29.1%	45.0%	
HISPANIC	19	83	166	1398	218	1,884
	1.0%	4.4%	8.8%	74.2%	11.6%	22.5%
	35.8%	45.9%	44.5%	23.3%	12.4%	
CHINESE	0	4	7	1321	423	1,755
	0.0%	0.2%	0.4%	75.3%	24.1%	21.0%
	0.0%	2.2%	1.9%	22.0%	24.0%	
BLACK	26	61	114	582	100	883
	2.9%	6.9%	12.9%	65.9%	11.3%	10.6%
	49.1%	33.7%	30.6%	9.7%	5.7%	
FILIPINO	0	8	32	471	111	622
	0.0%	1.3%	5.1%	75.7%	17.8%	7.4%
	0.0%	4.4%	8.6%	7.8%	6.3%	
VIETNAMESE	0	2	3	104	16	125
	0.0%	1.6%	2.4%	83.2%	12.8%	1.5%
	0.0%	1.1%	0.8%	1.7%	0.9%	
JAPANESE	0	0	0	56	24	80
	*	*	*	*	*	1.0%
	0.0%	0.0%	0.0%	0.9%	1.4%	
KOREAN	0	0	0	72	18	90
	*	*	*	*	*	1.1%
	0.0%	0.0%	0.0%	1.2%	1.0%	
OTHER ASIAN	2	4	6	91	29	132
	1.5%	3.0%	4.5%	68.9%	22.0%	1.6%
	3.8%	2.2%	1.6%	1.5%	1.6%	
PACIFIC ISLANDER	1	4	4	68	10	87
	*	*	*	*	*	1.0%
	1.9%	2.2%	1.1%	1.1%	0.6%	
NATIVE AMERICAN	0	2	1	11	1	15
	*	*	*	*	*	0.2%
	0.0%	1.1%	0.3%	0.2%	0.1%	
OTHER	2	0	2	67	10	81
	*	*	*	*	*	1.0%
	3.8%	0.0%	0.5%	1.1%	0.6%	
WITHHELD	0	0	2	18	7	27
	*	*	*	*	*	0.3%
	0.0%	0.0%	0.5%	0.3%	0.4%	
Total	53	181	373	6,002	1,759	8,368
	0.6%	2.2%	4.5%	71.7%	21.0%	

\* Percents not calculated for row categories with <100 items.

Note: Hispanic includes any race/ethnicity; all other races are non-Hispanic.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 10/97

**TABLE 1d: 1996 SAN FRANCISCO RESIDENT LIVE BIRTHS BY  
MOTHER'S RESIDENCE ZIP CODE AND AGE GROUP**

ZIP CODE	AGE GROUP					Total	%
	12-15	16-17	18-19	20-34	35+		
94102	4	5	14	191	40	254	3.0%
94103	2	5	20	155	38	220	2.6%
94107	0	4	11	117	44	176	2.1%
94108	0	0	1	63	27	91	1.1%
94109	1	1	15	311	86	414	4.9%
94110	7	49	86	821	161	1,124	13.4%
94112	6	28	70	798	196	1,098	13.1%
94114	0	1	1	135	75	212	2.5%
94115	8	16	17	199	58	298	3.6%
94116	2	3	3	312	132	452	5.4%
94117	1	4	8	173	77	263	3.1%
94118	5	8	4	257	103	377	4.5%
94121	2	0	2	307	125	436	5.2%
94122	0	6	12	406	140	564	6.7%
94123	0	0	1	140	50	191	2.3%
94124	7	31	57	385	58	538	6.4%
94127	0	2	2	108	55	167	2.0%
94130	0	0	2	65	10	77	0.9%
94131	1	4	7	186	74	272	3.3%
94132	1	2	6	184	53	246	2.9%
94133	2	0	2	202	60	266	3.2%
94134	4	12	31	444	76	567	6.8%
OTHER SF	0	0	0	42	21	63	0.8%
UNKNOWN	0	0	1	1	0	2	0.0%
<b>Total</b>	<b>53</b>	<b>181</b>	<b>373</b>	<b>6,002</b>	<b>1,759</b>	<b>8,368</b>	

Note: OTHER SF includes zip areas 94104-105, 94111 and 94129 that are assigned to 61 births, and P O Box codes for 2 births.

Source: San Francisco County AVSS Birth Records. Prepared by BEDCA, Dept. of Public Health, 11/97

**TABLE 2a: 1996 SAN FRANCISCO RESIDENT LIVE BIRTHS  
BY MOTHER'S ZIP CODE AND RACE GROUP**

ZIP CODE	RACE GROUP					WITHLD	Total	%
	WHITE	ASIAN	HISP	BLACK	OTHER			
94102	66	44	48	61	35	0	254	3.0%
94103	30	15	107	15	53	0	220	2.6%
94107	67	17	19	60	13	0	176	2.1%
94108	16	65	3	1	6	0	91	1.1%
94109	162	150	55	11	35	1	414	4.9%
94110	203	58	738	42	79	4	1,124	13.4%
94112	147	301	390	55	200	5	1,098	13.1%
94114	160	14	25	4	9	0	212	2.5%
94115	128	32	19	105	13	1	298	3.6%
94116	174	220	30	3	24	1	452	5.4%
94117	164	15	27	49	6	2	263	3.1%
94118	188	129	24	13	21	2	377	4.5%
94121	189	190	22	9	26	0	436	5.2%
94122	222	256	33	11	41	1	564	6.7%
94123	159	14	11	1	6	0	191	2.3%
94124	13	94	101	282	47	1	538	6.4%
94127	94	45	11	6	9	2	167	2.0%
94130	36	2	10	14	12	3	77	0.9%
94131	149	39	47	11	25	1	272	3.3%
94132	62	102	30	22	28	2	246	2.9%
94133	81	160	4	14	6	1	266	3.2%
94134	41	202	127	91	106	0	567	6.8%
OTHER SF	35	18	3	2	5	0	63	0.8%
UNKNOWN	1	0	0	1	0	0	2	0.0%
<b>Total</b>	<b>2,587</b>	<b>2,182</b>	<b>1,884</b>	<b>883</b>	<b>805</b>	<b>27</b>	<b>8,368</b>	<b>100.0%</b>

Definitions: HISPANIC includes any ethnicity; all other groups are non-Hispanic.

ASIAN—Chinese, Japanese, Korean, Vietnamese, Thai, Cambodian, Laotian, and other Asians not identified by a separate code. OTHER—Includes Filipino, Asian Indian, Pacific Islander, Native American, and Aleut.

Note: OTHER SF includes zip areas 94104-105, 94111 and 94129 that are assigned to 61 births; and post office box codes for 2 births.

Source: San Francisco County AVSS Birth Records. Prepared by BEDCA, Dept. of Public Health, 11/97

**TABLE 3a: 1996 S.F. RESIDENT LIVE BIRTHS TRIMESTER  
PRENATAL CARE BEGAN AND MOTHER'S AGE GROUP**

AGE GROUP	TRIMESTER			NO CARE	UNK	Total
	1ST	2ND	3RD			
<b>12-15</b>	25	22	4	2	0	<b>53</b>
	*	*	*	*	*	<b>0.6%</b>
	0.3%	2.5%	2.7%	3.1%	0.0%	
<b>16-17</b>	127	39	8	3	4	<b>181</b>
	70.2%	21.5%	4.4%	1.7%	2.2%	<b>2.2%</b>
	1.8%	4.5%	5.4%	4.7%	5.0%	
<b>18-19</b>	279	71	11	10	2	<b>373</b>
	74.8%	19.0%	2.9%	2.7%	0.5%	<b>4.5%</b>
	3.9%	8.2%	7.5%	15.6%	2.5%	
<b>20-34</b>	5157	641	101	44	59	<b>6,002</b>
	85.9%	10.7%	1.7%	0.7%	1.0%	<b>71.7%</b>
	71.5%	74.0%	68.7%	68.8%	73.8%	
<b>35+</b>	1623	93	23	5	15	<b>1,759</b>
	92.3%	5.3%	1.3%	0.3%	0.9%	<b>21.0%</b>
	22.5%	10.7%	15.6%	7.8%	18.8%	
<b>Total</b>	<b>7,211</b>	<b>866</b>	<b>147</b>	<b>64</b>	<b>80</b>	<b>8,368</b>
	<b>86.2%</b>	<b>10.3%</b>	<b>1.8%</b>	<b>0.8%</b>	<b>1.0%</b>	

\* Percents not calculated for row categories with <100 items.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 11/97

**TABLE 3b: 1996 S.F. RESIDENT LIVE BIRTHS BY TRIMESTER  
PRENATAL CARE BEGAN AND MOTHER'S ETHNICITY**

ETHNICITY	TRIMESTER			NO CARE	UNK	Total
	1ST	2ND	3RD			
WHITE	2433	112	19	16	7	2,587
	94.0%	4.3%	0.7%	0.6%	0.3%	30.9%
	33.7%	12.9%	12.9%	25.0%	8.8%	
HISPANIC	1439	349	61	14	21	1,884
	76.4%	18.5%	3.2%	0.7%	1.1%	22.5%
	20.0%	40.3%	41.5%	21.9%	26.3%	
CHINESE	1608	128	16	1	2	1,755
	91.6%	7.3%	0.9%	0.1%	0.1%	21.0%
	22.3%	14.8%	10.9%	1.6%	2.5%	
BLACK	671	147	17	24	24	883
	76.0%	16.6%	1.9%	2.7%	2.7%	10.6%
	9.3%	17.0%	11.6%	37.5%	30.0%	
FILIPINO	525	68	16	3	10	622
	84.4%	10.9%	2.6%	0.5%	1.6%	7.4%
	7.3%	7.9%	10.9%	4.7%	12.5%	
VIETNAMESE	113	8	3	0	1	125
	90.4%	6.4%	2.4%	0.0%	0.8%	1.5%
	1.6%	0.9%	2.0%	0.0%	1.3%	
JAPANESE	71	5	0	1	3	80
	*	*	*	*	*	1.0%
	1.0%	0.6%	0.0%	1.6%	3.8%	
KOREAN	85	4	0	0	1	90
	*	*	*	*	*	1.1%
	1.2%	0.5%	0.0%	0.0%	1.3%	
OTHER ASIAN	113	13	1	2	3	132
	85.6%	9.8%	0.8%	1.5%	2.3%	1.6%
	1.6%	1.5%	0.7%	3.1%	3.8%	
PACIFIC ISLANDER	51	23	7	2	4	87
	*	*	*	*	*	1.0%
	0.7%	2.7%	4.8%	3.1%	5.0%	
NATIVE AMERICAN	12	1	1	1	0	15
	*	*	*	*	*	0.2%
	0.2%	0.1%	0.7%	1.6%	0.0%	
OTHER	69	7	5	0	0	81
	*	*	*	*	*	1.0%
	1.0%	0.8%	3.4%	0.0%	0.0%	
WITHHELD	21	1	1	0	4	27
	*	*	*	*	*	0.3%
	0.3%	0.1%	0.7%	0.0%	5.0%	
Total	7,211	866	147	64	80	8,368
	86.2%	10.3%	1.8%	0.8%	1.0%	

\* Percents not calculated for row categories with <100 items.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 11/97

**TABLE 3c: 1996 S.F. RESIDENT LIVE BIRTHS BY TRIMESTER  
PRENATAL CARE BEGAN AND RESIDENCE ZIP CODE**

ZIP CODE	TRIMESTER			NO CARE	UNK	Total
	1ST	2ND	3RD			
94102	190	49	4	9	2	254
94103	161	30	12	7	10	220
94107	144	21	5	4	2	176
94108	78	11	2	0	0	91
94109	359	38	7	7	3	414
94110	879	188	42	6	9	1,124
94112	936	131	17	5	9	1,098
94114	200	10	1	1	0	212
94115	258	32	5	1	2	298
94116	424	22	4	0	2	452
94117	234	19	5	3	2	263
94118	351	21	3	0	2	377
94121	407	20	4	2	3	436
94122	527	30	3	2	2	564
94123	189	1	1	0	0	191
94124	404	94	14	10	16	538
94127	155	9	1	0	2	167
94130	65	10	0	0	2	77
94131	259	11	1	0	1	272
94132	233	9	1	2	1	246
94133	229	30	4	2	1	266
94134	468	79	10	3	7	567
OTHER SF	60	1	1	0	1	63
UNKNOWN	1	0	0	0	1	2
Total	7,211	866	147	64	80	8,368

Note: OTHER SF includes zip areas 94104-105, 94111 and 94129 that are assigned to 61 births; and post office box codes for 2 births.

Source: San Francisco County AVSS Birth Records. Prepared by BEDCA, Dept. of Public Health, 11/97

**TABLE 3cp: 1996 PERCENT OF S.F. RESIDENT LIVE BIRTHS BY  
TRIMESTER PRENATAL CARE BEGAN AND RESIDENCE ZIP CODE**

ZIP CODE	TRIMESTER			NO CARE	UNK	Total	% of Total
	1ST	2ND	3RD				
<b>94102<sup>a</sup></b>	74.8%	19.3%	1.6%	3.5%	0.8%	254	3.0%
<b>94103</b>	73.2%	13.6%	5.5%	3.2%	4.5%	220	2.6%
<b>94107</b>	81.8%	11.9%	2.8%	2.3%	1.1%	176	2.1%
<b>94108</b>	85.7%	12.1%	2.2%	0.0%	0.0%	91	1.1%
<b>94109</b>	86.7%	9.2%	1.7%	1.7%	0.7%	414	4.9%
<b>94110</b>	78.2%	16.7%	3.7%	0.5%	0.8%	1,124	13.4%
<b>94112</b>	85.2%	11.9%	1.5%	0.5%	0.8%	1,098	13.1%
<b>94114</b>	94.3%	4.7%	0.5%	0.5%	0.0%	212	2.5%
<b>94115</b>	86.6%	10.7%	1.7%	0.3%	0.7%	298	3.6%
<b>94116</b>	93.8%	4.9%	0.9%	0.0%	0.4%	452	5.4%
<b>94117</b>	89.0%	7.2%	1.9%	1.1%	0.8%	263	3.1%
<b>94118</b>	93.1%	5.6%	0.8%	0.0%	0.5%	377	4.5%
<b>94121</b>	93.3%	4.6%	0.9%	0.5%	0.7%	436	5.2%
<b>94122</b>	93.4%	5.3%	0.5%	0.4%	0.4%	564	6.7%
<b>94123</b>	99.0%	0.5%	0.5%	0.0%	0.0%	191	2.3%
<b>94124</b>	75.1%	17.5%	2.6%	1.9%	3.0%	538	6.4%
<b>94127</b>	92.8%	5.4%	0.6%	0.0%	1.2%	167	2.0%
<b>94130</b>	84.4%	13.0%	0.0%	0.0%	2.6%	77	0.9%
<b>94131</b>	95.2%	4.0%	0.4%	0.0%	0.4%	272	3.3%
<b>94132</b>	94.7%	3.7%	0.4%	0.8%	0.4%	246	2.9%
<b>94133</b>	86.1%	11.3%	1.5%	0.8%	0.4%	266	3.2%
<b>94134</b>	82.5%	13.9%	1.8%	0.5%	1.2%	567	6.8%
<b>OTHER SF</b>	95.2%	1.6%	1.6%	0.0%	1.6%	63	0.8%
<b>UNKNOWN</b>	50.0%	0.0%	0.0%	0.0%	50.0%	2	0.0%
<b>Total</b>	<b>7,211</b>	<b>866</b>	<b>147</b>	<b>64</b>	<b>80</b>	<b>8,368</b>	<b>100.0%</b>
	<b>86.2%</b>	<b>10.3%</b>	<b>1.8%</b>	<b>0.8%</b>	<b>1.0%</b>		

Note: OTHER SF includes zip areas 94104-105, 94111 and 94129 that are assigned to 61 births; and post office box codes to 2 births.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 11/97

**TABLE 4a: 1996 S.F. RESIDENT LIVE BIRTHS BY BIRTHWEIGHT GROUP AND MOTHER'S AGE GROUP**

AGE GROUP	WEIGHT GROUP			Total
	VLOW	LOW	NRM/HVY	
12-15	1	5	47	53
	*	*	*	0.6%
	1.1%	1.1%	0.6%	
16-17	3	12	166	181
	1.7%	6.6%	91.7%	2.2%
	3.2%	2.6%	2.1%	
18-19	2	26	345	373
	0.5%	7.0%	92.5%	4.5%
	2.2%	5.6%	4.4%	
20-34	60	314	5628	6,002
	1.0%	5.2%	93.8%	71.7%
	64.5%	67.2%	72.1%	
35+	27	110	1622	1,759
	1.5%	6.3%	92.2%	21.0%
	29.0%	23.6%	20.8%	
Total	93	467	7,808	8,368
	1.1%	5.6%	93.3%	

\* Percents not calculated for row categories with <100 items.

Definitions: VLOW = less than 1500 grams

LOW = 1500-2499 grams

NORM/HVY = 2500 grams and over

Source: San Francisco County AVSS Birth Records. Prepared by  
BEDC-A, Dept. of Public Health, 11/97

**TABLE 4c: 1996 S. F. RESIDENT LIVE BIRTHS BY BIRTH  
WEIGHT GROUP AND MOTHER'S ETHNICITY**

ETHNICITY	WEIGHT GROUP			Total
	VLOW	LOW	NRM/HVY	
<b>WHITE</b>	18	110	2,459	<b>2,587</b>
	0.7%	4.3%	95.1%	<b>30.9%</b>
	19.4%	23.6%	31.5%	
<b>HISPANIC</b>	22	84	1,778	<b>1,884</b>
	1.2%	4.5%	94.4%	<b>22.5%</b>
	23.7%	18.0%	22.8%	
<b>CHINESE</b>	13	84	1,658	<b>1,755</b>
	0.7%	4.8%	94.5%	<b>21.0%</b>
	14.0%	18.0%	21.2%	
<b>BLACK</b>	28	106	749	<b>883</b>
	3.2%	12.0%	84.8%	<b>10.6%</b>
	30.1%	22.7%	9.6%	
<b>FILIPINO</b>	6	50	566	<b>622</b>
	1.0%	8.0%	91.0%	<b>7.4%</b>
	6.5%	10.7%	7.2%	
<b>VIETNAMESE</b>	0	5	120	<b>125</b>
	0.0%	4.0%	96.0%	<b>1.5%</b>
	0.0%	1.1%	1.5%	
<b>JAPANESE</b>	0	3	77	<b>80</b>
	*	*	*	<b>1.0%</b>
	0.0%	0.6%	1.0%	
<b>KOREAN</b>	0	4	86	<b>90</b>
	*	*	*	<b>1.1%</b>
	0.0%	0.9%	1.1%	
<b>OTHER ASIAN</b>	2	8	122	<b>132</b>
	1.5%	6.1%	92.4%	<b>1.6%</b>
	2.2%	1.7%	1.6%	
<b>PACIFIC ISLANDER</b>	2	5	80	<b>87</b>
	*	*	*	<b>1.0%</b>
	2.2%	1.1%	1.0%	
<b>NATIVE AMERICAN</b>	0	1	14	<b>15</b>
	*	*	*	<b>0.2%</b>
	0.0%	0.2%	0.2%	
<b>OTHER</b>	1	5	75	<b>81</b>
	*	*	*	<b>1.0%</b>
	1.1%	1.1%	1.0%	
<b>WITHHELD</b>	1	2	24	<b>27</b>
	*	*	*	<b>0.3%</b>
	1.1%	0.4%	0.3%	
<b>Total</b>	<b>93</b>	<b>467</b>	<b>7,808</b>	<b>8,368</b>
	<b>1.1%</b>	<b>5.6%</b>	<b>93.3%</b>	

\* Percents not calculated for row categories with <100 items.

Note: Hispanic includes any race; all other races are non-Hispanic.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 11/97

**TABLE 4d: 1996 S.F. RESIDENT LIVE BIRTHS BY BIRTH  
WEIGHT GROUP AND RESIDENCE ZIP CODE**

ZIP CODE	WEIGHT GROUP			Total	% of Total
	VLOW	LOW	NRM/HVY		
94102	4	18	232	254	3.0%
94103	3	19	198	220	2.6%
94107	2	18	156	176	2.1%
94108	0	5	86	91	1.1%
94109	8	23	383	414	4.9%
94110	10	61	1053	1,124	13.4%
94112	11	54	1033	1,098	13.1%
94114	3	6	203	212	2.5%
94115	5	16	277	298	3.6%
94116	6	22	424	452	5.4%
94117	2	21	240	263	3.1%
94118	0	19	358	377	4.5%
94121	4	14	418	436	5.2%
94122	2	22	540	564	6.7%
94123	3	9	179	191	2.3%
94124	9	53	476	538	6.4%
94127	1	11	155	167	2.0%
94130	2	5	70	77	0.9%
94131	2	8	262	272	3.3%
94132	3	10	233	246	2.9%
94133	4	15	247	266	3.2%
94134	8	35	524	567	6.8%
OTHER SF	1	3	59	63	0.8%
UNKNOWN	0	0	2	2	0.0%
<b>Total</b>	<b>93</b>	<b>467</b>	<b>7,808</b>	<b>8,368</b>	<b>100.0%</b>

Note: OTHER SF includes zip areas 94104-105, 94111 and 94129 assigned to 49 births, and PO Box codes assigned to 2 records.

Definitions: VLOW= less than 1500 grams  
 LOW = 1500 - 2499 grams  
 NRM/HVY = 2500 grams and over

Source: San Francisco County AVSS Birth Records. Prepared by BEDC-A, Dept. of Public Health, 11/97

**Leading Causes of Death, Ranked by SEYLLs\*,  
Ages 0-24, By Age Groups,  
San Francisco, 1990-95**

Rank	Ages 0-24 (n=1,027)	Age < 1 (n=362)	Ages 1-4 (n=72)	Ages 5-14 (n=76)	Ages 15-24 (n=517)
1	Homicide 11604 (175)	SIDS 7012 (85)	Congenital anomalies 1309 (16)	M. Vehicle-Traffic 1130 (15)	Homicide 10180 (157)
2	Congenital anomalies 8323 (104)	Congenital anomalies 5775 (70)	Homicide 573 (7)	Congenital anomalies 594 (8)	Suicide 5067 (79)
3	SIDS 7012 (85)	Birth asphyxia & trauma 3548 (43)	M. Vehicle-Traffic 409 (5)	Homicide 521 (7)	M. Vehicle-Traffic 5024 (78)
4	M. Vehicle-Traffic 6646 (99)	Growth/gestation/LBW 1155 (14)	Fires, UI 327 (4)	Leukemia 385 (5)	HIV/AIDS 1892 (30)
5	Suicide 5140 (80)	Pneumonia 660 (8)	Brain cancer 246 (3)	Brain cancer 297 (4)	Drug poisoning, UI 1398 (22)
6	Birth asphyxia & trauma 3630 (44)	Diarrhea 412 (5)	HIV/AIDS 246 (3)	HIV/AIDS 297 (4)	Drownings, UI 782 (12)
7	HIV/AIDS 2682 (40)	Homicide 330 (4)	Drownings, UI 164 (2)	Drownings, UI 219 (3)	Congenital anomalies 646 (10)
8	Endo/metabolism 1412 (18)	HIV/AIDS 248 (3)	COPD 164 (2)	Inflam/cardiomyop 156 (2)	Falls, UI 573 (9)
9	Drug poisonings, UI 1398 (22)	Fires, UI 165 (2)	Inflam/cardiomyop 164 (2)	Lymphomas/m. myeloma 156 (2)	Lymphomas/m. myeloma 519 (8)
10	Drownings, UI 1165 (17)	Inflam/cardiomyop 165 (2)	Dementia/degen CNS 164 (2)	Fires, UI 151 (2)	Firearm, UI 466 (7)

Sources: Death Records (Public Health Information System); San Francisco Department of Public Health (SEYLLs analysis)

\*Note: SEYLLs= Standardized Expected Years of Life Lost. Number of deaths in parentheses.

**Leading Causes of Death, Ranked by SEYLLs\*,  
Ages 0-24, By Age Groups, Males Only,  
San Francisco, 1990-95**

Rank	Ages 0-24 (n=716)	Age < 1 (n=209)	Ages 1-4 (n=42)	Ages 5-14 (n=49)	Ages 15-24 (n=416)
1	Homicide 10386 (157)	SIDS 4538 (55)	Congenital anomalies 818 (10)	M. Vehicle-Traffic 672 (9)	Homicide 9282 (143)
2	Congenital anomalies 4978 (62)	Congenital anomalies 3465 (42)	Homicide 491 (6)	Homicide 448 (6)	Suicide 4164 (65)
3	M. Vehicle-Traffic 4724 (71)	Asphyxia & trauma 1650 (20)	Fires, UI 246 (3)	Congenital anomalies 375 (5)	M. Vehicle-Traffic 3806 (59)
4	SIDS 4538 (55)	Growth/gestation/LBW 742 (9)	M. Vehicle-Traffic 246 (3)	Brain cancer 297 (4)	HIV/AIDS 1829 (29)
5	Suicide 4237 (66)	Pneumonia 330 (4)	Leukemia 164 (2)	HIV/AIDS 224 (3)	Drug poisoning, UI 1009 (16)
6	HIV/AIDS 2217 (34)	Diarrhea 248 (3)	Pneumonia 164 (2)	Drownings, UI 219 (3)	Drownings, UI 719 (11)
7	Asphyxia & trauma 1650 (20)	Homicide 165 (2)	Drownings, UI 82 (1)	Inflam/cardiomyop 156 (2)	Firearm, UI 466 (7)
8	Drownings, UI 1020 (15)	Inflam/cardiomyop 165 (2)	Falls, UI 82 (1)	Lymphomas/m. myeloma 156 (2)	Falls, UI 446 (7)
9	Drug poisoning, UI 1009 (16)	Fires, UI 82 (1)	Inflam/cardiomyop 82 (1)	Leukemia 151 (2)	Leukemia 398 (6)
10	Growth/gestation/LBW 742 (9)	Falls, UI 82 (1)	Stroke 82 (1)	Suicide 73 (1)	Congenital anomalies 320 (5)

Sources: Death Records (Public Health Information System); San Francisco Department of Public Health (SEYLLs analysis)

\*Note: SEYLLs= Standardized Expected Years of Life Lost. Number of deaths in parentheses.

**Leading Causes of Death, Ranked by SEYLLs\*,  
Ages 0-24, By Age Groups, Females Only,  
San Francisco, 1990-95**

Rank	Ages 0-24 (n=311)	Age < 1 (n=153)	Ages 1-4 (n=30)	Ages 5-14 (n=27)	Ages 15-24 (n=101)
1	Congenital anomalies 3345 (42)	SIDS 2475 (30)	Congenital anomalies 491 (6)	M. Vehicle-Traffic 458 (6)	M. Vehicle-Traffic 1218 (19)
2	SIDS 2475 (30)	Congenital anomalies 2310 (28)	M. Vehicle-Traffic 164 (2)	Leukemia 234 (3)	Suicide 903 (14)
3	Asphyxia & trauma 1980 (24)	Asphyxia & trauma 1898 (23)	COPD 164 (2)	Congenital anomalies 219 (3)	Homicide 898 (14)
4	M. Vehicle-Traffic 1922 (28)	Growth/gestation/LBW 412 (5)	Dementia/degen CNS 164 (2)	Stroke 151 (2)	Drug poisoning, UI 388 (6)
5	Homicide 1218 (18)	Pneumonia 330 (4)	Brain cancer 164 (2)	Fires, UI 78 (1)	Congenital anomalies 325 (5)
6	Endo/metabol/im 966 (12)	Homicide 165 (2)	HIV/AIDS 164 (2)	Homicide 73 (1)	Lymphomas/m. myeloma 199 (3)
7	Suicide 903 (14)	Diarrhea 165 (2)	Homicide 82 (1)	HIV/AIDS 73 (1)	Fires, UI 131 (2)
8	HIV/AIDS 465 (6)	HIV/AIDS 165 (2)	Drownings, UI 82 (1)	Ovarian cancer 131 (2)	Pneumonia 131 (2)
9	Pneumonia 461 (6)	Fires, UI 82 (1)	Fires, UI 82 (1)		Falls, UI 126 (2)
10	Growth/gestation/LBW 412 (5)	M. Vehicle-Traffic 82 (1)	Inflam/cardiomyop 82 (1)		

Sources: Death Records (Public Health Information System); San Francisco Department of Public Health (SEYLLs analysis)

\*Note: SEYLLs= Standardized Expected Years of Life Lost. Number of deaths in parentheses.

**Number of Deaths and Death Rates,  
Ages 0-24, By Age Groups and Gender,  
San Francisco, 1990-95**

<b>Number of Deaths</b> <u>Gender</u>	<b>Age Group</b>				
	<1	1-4	5-14	15-24	Total
Male	209	42	49	416	716
Female	153	30	27	101	311
Total	362	72	76	517	1,027
Percent in Age Group	35%	7%	7%	50%	100%
Male/Female Ratio	1.4	1.4	1.8	4.1	2.3

<b>Death Rates</b> <u>Gender</u>	<b>Age Group</b>				
	<1	1-4	5-14	15-24	Total
Male	-	39.6	24.2	166.1	30.7
Female	-	29.4	14.6	42.6	19.9
Total	-	34.6	19.5	106.2	25.4
Male/Female Ratio	-	1.3	1.7	3.9	1.5

Sources: Death Records (Public Health Information System);

California Department of Finance 1993 population projections

\* Note: Age-specific death rates per 100,000 population, annualized.

TABLE 22a: 1996 FETAL, NEONATAL, POST-NEONATAL AND INFANT DEATHS  
BY MOTHER'S AGE GROUP AND ETHNICITY  
SAN FRANCISCO RESIDENTS AT TIME OF BIRTH AND DEATH

FETAL AND INFANT DEATHS								
MOTHER'S AGE	1996 LIVE BIRTHS	FETAL DEATH #	NEO- NATAL #	POST NEO NATAL #	FETAL DEATH RATIO	NEO- NATAL DEATH RATE	POST NEO- NATAL INFANT RATE	INFANT DEATH RATE
12 - 15	53	1	0	0	*	-	-	-
16 - 17	181	1	0	1	*	-	*	*
18 - 19	373	2	3	0	*	*	*	*
<20	607	4	3	1	*	*	*	*
20 - 34	6,002	27	16	10	4.5	2.7	1.7	4.3
35+	1,759	16	7	3	9.1	4.0	*	5.7
TOTAL	8,368	47	26	14	5.6	3.1	1.7	4.8

FETAL AND INFANT DEATHS								
MOTHER'S ETHNICITY	1996 LIVE BIRTHS	FETAL DEATH #	NEO- NATAL #	POST NEO NATAL #	FETAL DEATH RATIO	NEO- NATAL DEATH RATE	POST NEO- NATAL INFANT RATE	INFANT DEATH RATE
WHITE	2,587	13	5	2	5.0	1.9	*	2.7
HISPANIC	1,884	12	7	6	6.4	3.7	3.2	6.9
BLACK	883	6	6	5	6.8	6.8	5.7	12.5
CHINESE	1,755	8	3	0	4.6	*	-	*
FILIPINO	622	3	2	0	*	*	-	*
OTHER	610	5	2	1	8.2	*	*	*
UNKNOWN	27	0	1	0	-	*	-	*
TOTAL	8,368	47	26	14	5.6	3.1	1.7	4.8

\* Rates not calculated for < 100 births, for categories with fewer than five deaths, or for missing ethnicity.

Definitions: Neonatal death rate: Deaths ranging from 0-27 days per 1000 live births.

Post-neonatal death rate: Deaths from 28-364 days per 1000 live births.

Infant death rate: All deaths occurring less than 365 days after birth, per 1000 live births.

Fetal death ratio: Fetal deaths (>20 weeks gestation) per 1000 live births.

Source: San Francisco County AVSS Birth Records. Prepared by BEDC, Dept. of Public Health, 11/97

**Injury Deaths, Ages 0-18,  
By Cause (Mechanism), Age Group, Gender, and Race/Ethnicity,  
San Francisco Residents, 1986-1995**

Cause (Mechanism) and Intent	1995	1986-1995	Age Group				Gender		Race/Ethnicity				
			0-4	5-9	10-14	15-18	M	F	White	Hispanic	Black	Asian	Other
Unintentional	0	2	0	0	0	2	2	0	1	0	0	1	0
Suicide	1	11	0	0	0	11	9	2	7	1	1	2	0
Homicide	1	57	1	1	9	46	53	4	3	14	27	9	4
Undetermined Intent	0	1	0	0	0	1	1	0	0	0	0	1	0
<b>Subtotal, Firearms</b>	<b>2</b>	<b>71</b>	<b>1</b>	<b>1</b>	<b>9</b>	<b>60</b>	<b>65</b>	<b>6</b>	<b>11</b>	<b>15</b>	<b>28</b>	<b>13</b>	<b>4</b>
Unintentional	1	67	9	13	11	34	40	27	18	6	17	25	1
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Motor Vehicle Traffic</b>	<b>1</b>	<b>67</b>	<b>9</b>	<b>13</b>	<b>11</b>	<b>34</b>	<b>40</b>	<b>27</b>	<b>18</b>	<b>6</b>	<b>17</b>	<b>25</b>	<b>1</b>
Unintentional	3	16	13	0	1	2	12	4	1	4	6	5	0
Suicide	2	10	1	0	1	8	8	2	0	4	3	2	1
Homicide	0	2	1	0	0	1	2	0	0	0	1	0	1
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Suffocation</b>	<b>5</b>	<b>28</b>	<b>15</b>	<b>0</b>	<b>2</b>	<b>11</b>	<b>22</b>	<b>6</b>	<b>1</b>	<b>8</b>	<b>10</b>	<b>7</b>	<b>2</b>
Unintentional	0	16	4	1	5	6	14	2	4	1	4	6	1
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Drowning</b>	<b>0</b>	<b>16</b>	<b>4</b>	<b>1</b>	<b>5</b>	<b>6</b>	<b>14</b>	<b>2</b>	<b>4</b>	<b>1</b>	<b>4</b>	<b>6</b>	<b>1</b>
Unintentional	1	10	5	2	0	3	7	3	2	2	2	4	0
Suicide	2	3	1	0	0	2	2	1	2	1	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Falls</b>	<b>3</b>	<b>13</b>	<b>6</b>	<b>2</b>	<b>0</b>	<b>5</b>	<b>9</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>4</b>	<b>0</b>
Unintentional	3	11	7	2	2	0	8	3	3	6	2	0	0
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	2	2	0	0	0	0	2	0	2	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Flame/Smoke</b>	<b>3</b>	<b>13</b>	<b>9</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>8</b>	<b>5</b>	<b>3</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>0</b>
Unintentional	0	8	1	2	0	5	5	3	3	1	3	1	0
Suicide	0	2	0	0	0	2	0	2	1	0	0	1	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	3	2	0	0	1	3	0	0	2	1	0	0
<b>Subtotal, Poisoning</b>	<b>0</b>	<b>13</b>	<b>3</b>	<b>2</b>	<b>0</b>	<b>8</b>	<b>8</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>0</b>
Unintentional	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide	0	1	0	0	0	1	1	0	0	1	0	0	0
Homicide	1	8	2	1	0	5	7	1	0	3	1	4	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Cut/Pierce</b>	<b>1</b>	<b>9</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>6</b>	<b>8</b>	<b>1</b>	<b>0</b>	<b>4</b>	<b>1</b>	<b>4</b>	<b>0</b>

Cause (Mechanism) and Intent	1995	1986-1995	Age Group				Gender		Race/Ethnicity				
			0-4	5-9	10-14	15-18	M	F	White	Hisp'	Black	Asian	Other
Unintentional	0	3	0	2	1	0	2	1	0	0	2	1	0
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Other Transportation</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>0</b>
Unintentional	0	1	1	0	0	0	0	1	0	0	0	1	0
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Scalds</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>
Unintentional	0	1	1	0	0	0	1	0	0	0	0	0	1
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Struck By Obj'/Person</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Unintentional	0	5	2	0	2	1	2	3	2	1	1	1	0
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide	0	14	11	2	0	1	13	1	3	1	6	3	1
Undetermined Intent	1	2	2	0	0	0	0	2	2	0	0	0	0
<b>Subtotal, Unspecified/Other</b>	<b>1</b>	<b>21</b>	<b>15</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>15</b>	<b>6</b>	<b>7</b>	<b>2</b>	<b>7</b>	<b>4</b>	<b>1</b>
Unintentional	8	140	43	22	22	53	93	47	34	21	37	45	3
Suicide	5	27	2	0	1	24	20	7	10	7	4	5	1
Homicide	2	83	17	4	9	53	75	8	6	20	35	16	6
Undetermined Intent	1	6	4	0	0	2	4	2	2	2	1	1	0
<b>TOTAL, ALL CAUSES</b>	<b>16</b>	<b>256</b>	<b>66</b>	<b>26</b>	<b>32</b>	<b>132</b>	<b>192</b>	<b>64</b>	<b>52</b>	<b>50</b>	<b>77</b>	<b>67</b>	<b>10</b>

Source: California Department of Health Services, Death Certificates

**Injury Hospitalizations, Ages 0-18,  
By Cause (Mechanism), Intent, Age Group, Gender, and Race/Ethnicity,  
San Francisco Residents, 1995**

<b>Cause (Mechanism) and Intent</b>	<b>Total, 1995</b>	<b>Age Group</b>				<b>Gender</b>		<b>Race/Ethnicity</b>				
		<b>0-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-18</b>	<b>M</b>	<b>F</b>	<b>White</b>	<b>Hisp'</b>	<b>Black</b>	<b>Asian</b>	<b>Other</b>
Unintentional	122	50	34	25	13	82	40	35	29	28	26	4
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Falls</b>	<b>122</b>	<b>50</b>	<b>34</b>	<b>25</b>	<b>13</b>	<b>82</b>	<b>40</b>	<b>35</b>	<b>29</b>	<b>28</b>	<b>26</b>	<b>4</b>
Unintentional	43	21	2	11	9	22	21	14	4	10	7	8
Self-Inflicted	27	0	0	12	15	6	21	4	3	6	11	3
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	1	0	0	0	1	0	1	0	0	1	0	0
<b>Subtotal, Poisoning</b>	<b>71</b>	<b>21</b>	<b>2</b>	<b>23</b>	<b>25</b>	<b>28</b>	<b>43</b>	<b>18</b>	<b>7</b>	<b>17</b>	<b>18</b>	<b>11</b>
Unintentional	69	12	22	10	25	39	30	10	17	24	16	2
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	1	0	0	0	1	1	0	1	0	0	0	0
<b>Subtotal, Motor Vehicle Traffic</b>	<b>70</b>	<b>12</b>	<b>22</b>	<b>10</b>	<b>26</b>	<b>40</b>	<b>30</b>	<b>11</b>	<b>17</b>	<b>24</b>	<b>16</b>	<b>2</b>
Unintentional	16	4	4	3	5	12	4	2	2	5	5	2
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	25	0	0	6	19	22	3	5	8	6	4	2
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Cut/Pierce</b>	<b>41</b>	<b>4</b>	<b>4</b>	<b>9</b>	<b>24</b>	<b>34</b>	<b>7</b>	<b>7</b>	<b>10</b>	<b>11</b>	<b>9</b>	<b>4</b>
Unintentional	13	1	3	3	6	9	4	4	3	2	2	2
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	24	0	1	5	18	18	6	3	9	8	4	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Struck by Obj'/Person</b>	<b>37</b>	<b>1</b>	<b>4</b>	<b>8</b>	<b>24</b>	<b>27</b>	<b>10</b>	<b>7</b>	<b>12</b>	<b>10</b>	<b>6</b>	<b>2</b>
Unintentional	5	0	0	0	5	5	0	1	1	0	3	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	23	0	0	4	19	20	3	2	5	8	7	1
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Firearms</b>	<b>28</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>24</b>	<b>25</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>8</b>	<b>10</b>	<b>1</b>
Unintentional	22	19	1	2	0	15	7	3	8	3	8	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Scalds</b>	<b>22</b>	<b>19</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>15</b>	<b>7</b>	<b>3</b>	<b>8</b>	<b>3</b>	<b>8</b>	<b>0</b>
Unintentional	11	1	3	6	1	7	4	3	4	4	0	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Other Transportation</b>	<b>11</b>	<b>1</b>	<b>3</b>	<b>6</b>	<b>1</b>	<b>7</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>4</b>	<b>0</b>	<b>0</b>

Cause (Mechanism) and Intent	Total, 1995	Age Group				Gender		Race/Ethnicity				
		0-4	5-9	10-14	15-18	M	F	White	Hisp'	Black	Asian	Other
Unintentional	11	4	3	3	1	6	5	1	1	9	0	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Bites/Stings</b>	<b>11</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>6</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>9</b>	<b>0</b>	<b>0</b>
Unintentional	8	6	2	0	0	3	5	1	2	4	0	1
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Flame/Smoke</b>	<b>8</b>	<b>6</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>4</b>	<b>0</b>	<b>1</b>
Unintentional	5	5	0	0	0	2	3	1	1	3	0	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Suffocation</b>	<b>5</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>0</b>	<b>0</b>
Unintentional	2	2	0	0	0	1	1	1	0	0	1	0
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Drowning</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>
Unintentional	63	26	13	9	15	47	16	14	12	13	22	2
Self-Inflicted	0	0	0	0	0	0	0	0	0	0	0	0
Assault	6	4	1	0	1	3	3	3	0	0	2	1
Undetermined Intent	0	0	0	0	0	0	0	0	0	0	0	0
<b>Subtotal, Unspecified/Other</b>	<b>69</b>	<b>30</b>	<b>14</b>	<b>9</b>	<b>16</b>	<b>50</b>	<b>19</b>	<b>17</b>	<b>12</b>	<b>13</b>	<b>24</b>	<b>3</b>
Unintentional	390	151	87	72	80	250	140	90	84	105	90	21
Self-Inflicted	27	0	0	12	15	6	21	4	3	6	11	3
Assault	78	4	2	15	57	63	15	13	22	22	17	4
Undetermined Intent	2	0	0	0	2	1	1	1	0	1	0	0
<b>TOTAL, ALL CAUSES</b>	<b>497</b>	<b>155</b>	<b>89</b>	<b>99</b>	<b>154</b>	<b>320</b>	<b>177</b>	<b>108</b>	<b>109</b>	<b>134</b>	<b>118</b>	<b>28</b>

Source: California Department of Health Services, Office of Statewide Health Planning and Development, Hospital Discharge data

Note: Data includes hospitalizations of San Francisco residents treated for injuries at hospitals located in San Francisco.

# Health Care Provider's Guide to the Requirements of The California School Immunization Law

Reference: Health and Safety Code, Sections 120325-120375 (formerly Sections 3380-3390); California Code of Regulations, Title 17, Sections 6000-6075

As of **August 1997**, two new requirements take effect: a hepatitis B series (kindergarten and child care) and a second dose of measles vaccine (kindergarten). Children must have their immunizations before they can attend school or child care in California.<sup>1</sup> Parents must present their child's Immunization Record to school or child care staff prior to admission as proof of immunization. Health care providers are required to give or update the parent's copy of the child's Immunization Record whenever these immunizations are administered. Children who have not completed all immunizations will be admitted if they are up-to-date, provided they obtain the next vaccines when due.

## Requirements for School Entry (K-12)<sup>1</sup>

Polio	<b>4 doses, but 3 doses are enough</b> if at least one was given after the 2nd birthday.
DTP/DTaP/DT/d <sup>2</sup>	<b>4 or more doses, but one more dose is needed</b> if the last dose was given before the 2nd birthday. After the 7th birthday, at least three doses are needed, but one must be on or after the 2nd birthday.
MMR <sup>3</sup>	<b>2 doses for kindergarten entry.</b> <b>1 dose for grades 1-12.</b> A second dose is recommended.
Hepatitis B	<b>3 doses, for kindergarten entry only.</b>

## Requirements for Child Care Entry<sup>1</sup>

Age of Child	Number of Doses Required
Under 2 months	None Required
2-3 months	1 Polio, 1 DTP/DTaP/DT, 1 Hib, 1 Hepatitis B
4-5 months	2 Polio, 2 DTP/DTaP/DT, 2 Hib, 2 Hepatitis B
6-14 months	2 Polio, 3 DTP/DTaP/DT, 2 Hib, 2 Hepatitis B
15-17 months	2 Polio, 3 DTP/DTaP/DT, 2 Hepatitis B, plus 1 MMR and 1 Hib—both of these given on or after the first birthday.
18 months-5 years	3 Polio, 4 DTP/DTaP/DT, 3 Hepatitis B, plus 1 MMR and 1 Hib*—both of these given on or after the first birthday.

\*The Hib requirement applies only to children under age 4 years and 6 months.

<sup>1</sup> The law allows permanent or temporary exemptions for medical reasons or if immunizations are contrary to the religious or personal beliefs of the parent or guardian. For medical contraindications, please give parents a signed note specifying the reason for and duration of the exemption so they can submit it to the school or center. For exemptions for mumps or rubella vaccines because the child had the disease, you must note that you have laboratory evidence of immunity.

<sup>2</sup> For children under 7 years of age, please give parents a signed note if pertussis vaccine is contraindicated. Pertussis vaccine is not required for children 7 years of age and older.

<sup>3</sup> MMR doses must be on or after the first birthday. Mumps is not required for those 7 years of age and older. For kindergarten entrants, one dose must be MMR; the other dose may be any measles-containing vaccine given on or after the first birthday (MMR vaccine usually will be used).

For further information, or for free supplies of the California Immunization Record, please call the Immunization Coordinator at your local health department.

415/554-2833



# Recommended Childhood Immunization Schedule United States, January - December 1998

Vaccines<sup>d</sup> are listed under the routinely recommended ages. **Bars** indicate range of acceptable ages for immunization. Catch-up immunization should be done during any visit when feasible. **Shaded ovals** indicate vaccines to be assessed and given if necessary during the early adolescent visit.

Age Vaccine ▼	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B <sup>2,3</sup>	Hep B-1									Hep B <sup>3</sup>	
Diphtheria, Tetanus, Pertussis <sup>4</sup>			Hep B-2								
				DTaP or DTP	DTaP or DTP		DTaP or DTP <sup>4</sup>		DTaP or DTP	Td	
<i>H. influenzae</i> type b <sup>5</sup>			Hib	Hib	Hib		Hib				
Polio <sup>6</sup>			Polio <sup>6</sup>	Polio			Polio <sup>6</sup>		Polio		
Measles, Mumps, Rubella <sup>7</sup>							MMR		MMR <sup>7</sup>	MMR <sup>7</sup>	
Varicella <sup>8</sup>							Var			Var <sup>8</sup>	

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP),  
and the American Academy of Family Physicians (AAFP).

**Reported Cases of Selected Communicable Diseases,  
Ages 0-18, 19-24, and All Ages,  
San Francisco, 1990-1996**

<u>Vaccine-Preventable</u>	AGES 0-18										AGES 19-24	
	1990	1991	1992	1993	1994	1995	1996	1997	Total	% of All	Total	% of All
Diphtheria	0	1	0	0	0	0	0	0	1	100%	0	0%
Hepatitis A	25	17	37	17	23	48	34	29	230	7%	408	13%
Hepatitis B	20	7	5	3	1	2	2	0	40	6%	125	20%
Hib	2	6	2	2	0	2	0	0	14	10%	4	3%
Measles	17	1	0	0	2	1	1	0	22	42%	6	12%
Mumps	1	5	3	1	0	1	0	2	13	46%	3	11%
Polio	0	0	0	0	0	0	0	0	0	-	0	-
Rubella	0	0	2	0	1	0	0	0	3	38%	0	0%
Tetanus	0	0	0	0	0	0	0	0	0	0%	0	0%
Whooping Cough	3	3	5	4	10	18	11	9	63	86%	1	1%
<u>Not Vaccine-Preventable</u>												
Campylobacter	192	213	188	171	178	144	168	170	1,424	27%	452	9%
Giardia	116	102	67	76	79	67	84	64	655	23%	191	7%
Salmonella	78	67	81	96	80	68	65	79	614	38%	116	7%
Shigella	87	72	140	85	74	72	55	42	627	28%	116	5%
Tuberculosis	18	19	17	12	7	6	10	*	*	*	*	*

	ALL AGES								
<u>Vaccine-Preventable</u>	1990	1991	1992	1993	1994	1995	1996	1997	Total
Diphtheria	0	1	0	0	0	0	0	0	1
Hepatitis A	272	384	381	220	293	450	577	599	3,176
Hepatitis B	154	80	76	75	71	50	58	57	621
Hib	24	19	10	17	8	32	11	13	134
Measles	37	3	1	4	2	2	2	1	52
Mumps	6	5	3	2	5	2	1	4	28
Polio	0	0	0	0	0	0	0	0	0
Rubella	1	1	2	0	1	3	0	0	8
Tetanus	1	0	0	0	0	0	0	0	1
Whooping Cough	3	5	5	4	12	23	11	10	73
<u>Not Vaccine-Prev'ble</u>									
Campylobacter	781	788	711	625	614	560	596	584	5,259
Giardia	349	314	263	347	405	410	398	384	2,870
Salmonella	213	198	218	200	199	193	182	216	1,619
Shigella	361	274	340	245	238	327	256	211	2,252
Tuberculosis	334	333	355	356	280	270	261	242	2,431

Sources: 1) San Francisco Department of Public Health, Community Health Epidemiology, May 1998

2) San Francisco Department of Public Health, TB Control Program

Notes: 1) Also refer to separate detailed report on Reported Cases of TB (By Ethnicity, By Place of Birth).

\*2) 1997 data for persons age 0-18 is pending.

Commudz.xls, 90-97 0-18; All

6/30/98

**SEXUALLY TRANSMITTED DISEASES,  
REPORTED CASES AND RATES, BY AGE GROUPS,  
SAN FRANCISCO, 1992-1996**

	Reported Cases						Rates				
	1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996
<b><u>Chlamydia</u></b>											
Ages 15-19	746	687	703	568	570	3,274	2110	1943	1988	1606	1612
Ages 20-24	717	716	637	526	578	3,174	1213	1211	1078	890	978
Ages 25+	745	794	784	655	756	3,734	-	-	-	-	-
Total, All Ages	2,208	2,197	2,124	1,749	1,904	10,182	305	304	293	242	263
15-19 : All (Ratio)							6.9	6.4	6.8	6.6	6.1
15-19 vs. All (%)							592%	540%	578%	565%	513%
<b><u>Gonorrhea</u></b>											
Ages 15-19	428	312	354	246	190	1,530	1210	882	1001	696	537
Ages 20-24	589	422	435	280	234	1,960	997	714	736	474	396
Ages 25+	1,655	1,314	1,098	1,114	1,039	6,220	-	-	-	-	-
Total, All Ages	2,672	2,048	1,887	1,640	1,463	9,710	369	283	261	227	202
15-19 : All (Ratio)							3.3	3.1	3.8	3.1	2.7
15-19 vs. All (%)							228%	212%	284%	207%	166%
<b><u>Early Syphilis</u></b>											
Ages 15-19	6	5	3	0	2	16	17	14	9	0	6
Ages 20-24	17	15	12	5	3	52	29	25	20	9	5
Ages 25+	110	73	44	37	39	303	-	-	-	-	-
Total, All Ages	133	93	59	42	44	371	18	13	8	6	6
15-19 : All (Ratio)							0.9	1.1	1.0	0.0	0.9
15-19 vs. All (%)							-8%	10%	5%	-100%	-7%

Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

Notes:

- 1) Rates for 25+ age group were not available.
- 2) Rates are equal to the number of STD cases within the specified population per 100,000 San Francisco residents in that population per year. Population figures for rates are from the 1990 U.S. Census.

**SEXUALLY TRANSMITTED DISEASES,  
REPORTED CASES AND RATES, AGES 15 TO 19, BY GENDER,  
SAN FRANCISCO, 1992-1996**

	Reported Cases						Rates					
	1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996	
<u>Chlamydia</u>												
Female	622	567	591	484	483	2,747	3628	3308	3448	2823	2818	
Male	124	120	112	83	84	523	681	659	615	456	461	
Unknown	0	0	0	1	3	4	-	-	-	-	-	
Total/All	746	687	703	568	570	3,274	2110	1943	1988	1606	1612	
F : M (Ratio)							5.3	5.0	5.6	6.2	6.1	
15-19 : All (Ratio)							1.7	1.7	1.7	1.8	1.7	
15-19 vs. All (%)							72%	70%	73%	76%	75%	
<u>Gonorrhea</u>												
Female	243	196	254	177	144	1,014	1418	1143	1482	1033	840	
Male	185	116	100	69	46	516	1015	637	549	379	253	
Total/All	428	312	354	246	190	1,530	1210	882	1001	696	537	
F : M (Ratio)							1.4	1.8	2.7	2.7	3.3	
15-19 : All (Ratio)							1.2	1.3	1.5	1.5	1.6	
15-19 vs. All (%)							17%	30%	48%	48%	56%	
<u>Early Syphilis</u>												
Female	3	3	2	0	2	10	18	18	12	0	12	
Male	3	2	1	0	0	6	17	11	6	0	0	
Total/All	6	5	3	0	2	16	17	14	9	0	6	

Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

Notes:

1) Rates for 25+ age group were not available.

2) Rates are equal to the number of STD cases within the specified population per 100,000 San Francisco residents in that

SEXUALLY TRANSMITTED DISEASES,  
REPORTED CASES AND RATES,  
AGES 15 TO 19, BY RACE/ETHNICITY,  
SAN FRANCISCO, 1992-1996

	Reported Cases						Rates				
	1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996
<b><u>Chlamydia</u></b>											
Asian	60	57	78	56	62	313	414	393	538	386	428
African American	396	358	325	217	233	1,529	7780	7033	6385	4263	4578
Hispanic	131	106	115	94	70	516	1784	1444	1566	1280	953
Native American	2	3	3	1	4	13	1504	2256	2256	752	3008
White	65	39	54	55	36	249	791	474	657	669	438
Unknown	92	124	128	145	165	654	-	-	-	-	-
Total	746	687	703	568	570	3,274	2110	1943	1988	1606	1612
15-19 : All (Ratio)							3.7	3.6	3.2	2.7	2.8
15-19 vs. All (%)							269%	262%	221%	165%	184%
<b><u>Gonorrhea</u></b>											
Asian	12	8	8	2	4	34	83	55	55	14	28
African American	316	217	255	166	112	1,066	6208	4263	5010	3261	2200
Hispanic	42	30	19	19	16	126	572	409	259	259	218
Native American	2	6	3	0	1	12	1504	4511	2256	0	752
White	20	18	18	20	12	88	243	219	219	243	146
Unknown	36	33	51	39	45	204	-	-	-	-	-
Total	428	312	354	246	190	1,530	1210	882	1001	696	537
15-19 : All (Ratio)							5.1	4.8	5.0	4.7	4.1
15-19 vs. All (%)							413%	383%	400%	369%	310%

	Reported Cases						Rates					
	1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996	
Early Syphilis												
Asian	0	0	0	0	0	0	0	0	0	0	0	
African American	3	2	1	0	0	6	59	39	20	0	0	
Hispanic	2	1	1	0	1	5	27	14	14	0	14	
Native American	0	1	0	0	0	1	0	752	0	0	0	
White	1	1	1	0	1	4	12	12	12	0	12	
Total	6	5	3	0	2	16	17	14	9	0	6	

Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

Note: Rates are equal to the number of STD cases within the specified population per 100,000 San Francisco residents in that population per year. Population figures for rates are from the 1990 U.S. Census.

SEXUALLY TRANSMITTED DISEASES,  
REPORTED CASES,  
AGES 15 TO 19, BY ZIP CODE,  
SAN FRANCISCO, 1992-1996

Zip Code		Area/Neighborhood		REPORTED CASES																			
				Chlamydia										Gonorrhea						Early Syphilis			
				1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996	TOTAL	1992	1993	1994	1995	1996	TOTAL		
94102	Tenderloin/Hayes Val./N. of Market	40	37	29	28	16	150	36	20	17	13	3	89	0	0	0	0	0	0				
94103	South of Market	24	23	18	21	13	99	11	14	7	5	7	44	0	0	0	0	0	0				
94104	Rincon	1	0	0	0	0	1	2	1	0	0	0	3	0	0	0	0	0	0				
94105	Telegraph Hill	0	0	2	0	0	2	1	1	2	0	0	4	0	0	0	0	0	0				
94107	Potrero Hill	32	30	23	12	15	112	19	20	26	9	4	78	0	0	1	0	0	1				
94108	Chinatown	2	0	3	2	1	8	3	1	0	1	0	5	0	0	0	0	0	0				
94109	Polk/Russian Hill	14	8	17	12	14	65	5	5	2	5	5	22	0	0	0	0	0	0				
94110	Inner Mission/Bernal Hts.	100	76	96	50	56	378	41	34	17	17	19	128	2	0	0	0	1	3				
94112	Ingle/Exelsior/Crocker-Amazon	73	70	71	59	48	321	19	25	24	17	12	97	0	0	0	0	0	0				
94114	Castro, Noe Valley	7	7	10	9	7	40	2	1	0	3	0	6	0	0	0	0	0	0				
94115	Western Addition/Japantown	53	53	33	30	38	207	36	19	26	18	12	111	0	0	0	0	0	0				
94116	Parkside	5	8	13	11	6	43	0	1	0	7	3	11	0	0	0	0	0	0				
94117	Haight-Ashbury	29	29	20	30	19	127	27	15	18	11	9	80	0	1	0	0	0	1				
94118	Inner Richmond	16	6	12	12	5	51	7	5	2	1	1	16	0	0	0	0	0	0				
94121	Outer Richmond	12	7	6	10	9	44	4	1	3	0	0	8	0	0	0	0	0	0				
94122	Sunset	13	16	14	11	10	64	5	1	2	0	2	10	0	0	0	0	0	0				
94123	Marina	4	1	2	2	0	9	0	0	0	0	2	2	0	0	0	0	0	0				
94124	Bayview-Hunter's Point	154	113	145	100	104	616	105	59	114	78	44	400	2	0	0	0	0	2				
94127	St. Francis Wood; Miraloma/Senside	7	5	3	10	12	37	3	3	3	1	1	11	0	0	0	0	0	0				
94129	Presidio	4	3	1	0	0	8	0	0	0	0	1	1	0	0	0	0	0	0				
94130	Treasure Island	0	3	6	0	0	9	1	1	2	0	0	4	0	0	0	0	0	0				
94131	Twin Peaks-Glen Park	17	17	16	10	8	68	6	1	6	3	4	20	0	0	0	0	0	0				
94132	Lake Merced	14	11	23	18	15	81	9	8	10	5	3	35	0	0	0	0	0	0				
94133	North Beach/Chinatown	6	5	5	8	7	31	4	0	1	2	1	8	0	0	0	0	0	0				
94134	Visitation Valley/Sunnydale	73	87	72	46	46	324	49	35	40	23	13	160	1	2	0	0	0	3				
Other	-	2	6	3	3	3	17	0	4	1	4	2	11	0	0	0	0	0	0				
Missing	-	44	66	60	74	118	362	33	37	31	23	42	166	1	2	2	0	1	6				
Total		746	687	703	568	570	3,274	428	312	354	246	190	1,530	6	5	3	0	2	16				

Source: San Francisco Department of Public Health, Sexually Transmitted Disease Control Program, 1997

**AIDS INCIDENCE, MORTALITY, AND PREVALENCE,  
BY AGE GROUPS (0-29 YEARS OLD), 1980-98,  
SAN FRANCISCO, AS OF MARCH 31, 1998**

	NUMBER OF CASES BY AGE GROUPS					Number of Deaths	Number of Persons Living With AIDS
	0-12	13-19	20-24	25-29	TOTAL		
1980	2	0	0	0	2	0	2
1981	1	0	2	2	5	2	5
1982	1	0	2	17	20	6	19
1983	0	0	10	50	60	24	55
1984	0	3	17	75	95	53	97
1985	1	3	28	114	146	83	160
1986	3	1	24	159	187	110	237
1987	8	3	30	167	208	127	318
1988	2	1	41	193	237	133	422
1989	7	1	34	195	237	155	504
1990	3	0	36	201	240	171	573
1991	5	6	39	264	314	185	702
1992	2	2	54	321	379	199	882
1993	3	0	44	250	297	200	979
1994	3	5	34	182	224	226	977
1995	0	0	29	138	167	171	973
1996	0	2	25	92	119	88	1,004
1997	1	1	17	82	101	40	1,065
1998	0	0	1	6	7	6	1,066
TOTAL	42	28	467	2,508	3,045	1,979	-
% of Total	1%	1%	15%	82%	100%	-	-

Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, Special Report, April 1998

**REPORTED AIDS CASES, BY GENDER,  
SELECTED AGE GROUPS, AND RACE/ETHNICITY,  
SAN FRANCISCO, REPORTED THROUGH MARCH 31, 1998**

<u>Gender/Age Group</u>	ETHNICITY					TOTAL
	White	African-American	Latino	Asian/PacIsl	Native American	
<u>Male</u>						
0-12	11	3	6	3	0	23
13-19	10	1	11	2	1	25
20-24	289	55	78	16	2	440
25-29	1,686	254	366	75	17	2,398
30+	16,672	2,174	2,024	525	82	21,477
Subtotal, Male	18,668	2,487	2,485	621	102	24,363
	White	African-American	Latino	Asian/PacIsl	Native American	TOTAL
<u>Female</u>						
0-12	6	11	1	1	0	19
13-19	1	1	1	0	0	3
20-24	12	10	4	0	1	27
25-29	44	37	19	10	0	110
30+	252	313	84	41	9	699
Subtotal, Female	315	372	109	52	10	858
 TOTAL, All Ages	 18,983	 2,859	 2,594	 673	 112	 25,221

Source: San Francisco Department of Public Health, AIDS Office, Seroepidemiology and Surveillance Branch, AIDS Surveillance Report, March 31, 1998

**USE OF ALCOHOL, DRUGS, AND TOBACCO,  
LIFETIME AND MONTHLY REPORTED USE,  
SAN FRANCISCO PUBLIC SCHOOL STUDENTS (MIDDLE AND HIGH SCHOOL),  
1992, 1995, 1997**

	Lifetime Reported Use (Have Ever Tried)					
	Middle School			High School		
	1992	1995	1997	% Change 1992-1997	Average, 1992-1997	% Change 1992-1997
Alcohol	39%	50%	53%	36%	47%	59%
Marijuana	12%	15%	20%	67%	16%	34%
Cocaine	2%	3%	8%	300%	4%	8%
Inhalant	8%	12%	15%	88%	12%	8%
Tobacco	39%	37%	34%	-13%	37%	-4%

	Monthly Reported Use (Tried Within 30 Days)					
	Middle School			High School		
	1992	1995	1997	% Change 1992-1997	Average, 1992-1997	% Change 1992-1997
Alcohol	16%	19%	21%	31%	19%	30%
Marijuana	NA	NA	NA	-	-	18%
Cocaine	NA	NA	NA	-	-	2%
Tobacco	12%	11%	15%	25%	13%	22%
Sample Size	3,868	1,669	1,782	-	-	2,628
Enrollment	NA	13,153	12,327	-	-	19,215

Sources:

- 1) Youth Risk Behavior Survey - Preliminary Results, San Francisco Unified School District, 1997
- 2) Youth Risk Behavior Survey, San Francisco Unified School District, 1995

Note: The survey did not inquire regarding monthly inhalant use.

**EMERGENCY DEPARTMENT MENTIONS\*,  
BY DRUG CATEGORIES, AGE GROUPS, AND GENDER,  
RANKED BY DRUG CATEGORIES,  
SAN FRANCISCO METROPOLITAN AREA\*\*,  
1994**

DRUG CATEGORY	Age Group and Gender						TOTAL	
	6-17 Years			18-34 Years				
	Male	Female	Subtotal	Male	Female	Subtotal	#	%
Cocaine	20	14	34	959	480	1,439	1,473	17.8%
Heroin/Morphine	0	0	0	740	477	1,217	1,217	14.7%
Alcohol-in-combination	25	38	63	759	383	1,142	1,205	14.5%
Methamphetamine/Speed	16	19	35	584	161	745	780	9.4%
Marijuana/Hashish	43	19	62	217	67	284	346	4.2%
Amphetamine	0	0	0	191	58	249	249	3.0%
Acetaminophen	16	53	69	60	120	180	249	3.0%
LSD	35	10	45	70	12	82	127	1.5%
Aspirin	0	30	30	40	50	90	120	1.4%
Diazepam	0	0	0	62	41	103	103	1.2%
Diphenhydramine	0	0	0	41	59	100	100	1.2%
PCP/PCP Combinations	0	0	0	81	16	97	97	1.2%
OTC Sleep Aids	0	12	12	29	30	59	71	0.9%
Codeine Combinations	0	0	0	22	34	56	56	0.7%
Lorazepam	0	0	0	15	20	35	35	0.4%
Alprazolam	0	0	0	0	32	32	32	0.4%
Amitriptyline	0	0	0	12	19	31	31	0.4%
Methadone	0	0	0	10	17	27	27	0.3%
Chlorpromazine	0	0	0	16	0	16	16	0.2%
Fluoxetine	0	0	0	0	15	15	15	0.2%
Doxepin	0	0	0	0	13	13	13	0.2%
Thiorizadine	0	0	0	0	12	12	12	0.1%
Haloperidol	0	0	0	0	10	10	10	0.1%
All Other Drugs	74	144	218	551	557	1,108	1,326	16.0%
Drug Unknown	0	0	0	383	193	576	576	7.0%
TOTAL Mentions	229	339	568	4,842	2,876	7,718	8,286	100.0%
% Within Age Group	40%	60%	100%	63%	37%	100%	-	-
% of 6 to 34 Years of Age	3%	4%	7%	58%	35%	93%	100%	-
TOTAL Episodes***	143	229	372	3,279	1,882	5,161	5,533	

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Drug Abuse Warning Network (DAWN), October 1995 data file

Notes - see next page.

NOTES:

- 1) These are weighted estimates based on a representative sample of non-federal short-stay hospitals with 24-hour emergency departments.
- 2) \* Definition of "episode": A reported ED admission that involved drug abuse. Episodes involving children under 6 years of age are not reported. Patient identifiers are not collected and the episodes reported may include patients that make repeated visits to an ED or to several EDs. Definition of "mention": Refers to a substance that was mentioned in a drug abuse episode. In addition to alcohol-in-combination, up to 6 substances can be reported for each ED drug abuse episode; thus, the total number of mentions exceeds the number of total episodes. It should be noted that a drug mention may or may not be the confirmed "cause" of the episode in multiple-drug abuse cases. Even when only one substance is reported for an episode, allowance should still be made for reportable drugs not mentioned or for other contributory factors.
- 3) \*\* San Francisco Metropolitan Area includes San Francisco County, San Mateo County, and Marin County.

City and County of San Francisco Department of Public Health  
DIVISION OF POPULATION HEALTH AND PREVENTION

**Mental Health - Child, Youth and Family Services Section**

***Service System Principles & Goals.*** Children's mental health fully embraces the *National Institute of Mental Health Child and Adolescent Service Program (CASSP)*<sup>\*</sup> and *California Mental Health Performance Outcome* goals and objectives for children and youth with serious emotional, behavioral, and mental health problems and their families. Additionally, the Section is guided by values associated in building an integrated comprehensive children's system of care that is child centered, family focused, community based and culturally competent.

***Collaborative Planning & Services.*** Collaborative planning, programs, and services are essential to making a mental health continuum into a system of care. At the broadest level, community collaboration is made possible by the *Children's System of Care Policy and Planning Council*. Additional administrative coordination requires monthly interagency meetings between mental health and special education, social service, health and juvenile probation. A number of interagency work groups exist to review and authorize placement decisions (into residential, subacute, and day treatment programs) in conjunction with families and treatment personnel. Most all mental health programs and services are collaborative to some extent and in some way or another (e.g. cross-disciplinary, across child, youth and family serving departments and agencies, with community groups and organizations, and/or with family members and representatives). Prevention and early intervention programs, mental health and school partnerships, primary care mental health interface, and family involvement program represent an explicit public policy focus on collaborative human service programming. Other service delivery models exemplifying collaborative planning and services are: 1) the *Family Mosaic Project*, a nationally recognized, local model program for multi-agency collaboration, family participation, intensive case management, wrap around services and innovative community-based service delivery; 2) the *Foster Care Mental Health Program* providing screening, assessment and referral services for all children currently, or at-risk of being placed, in foster care; 3) a new program involving mental health screening, assessment and case management of Juvenile Probation youth with serious mental health problems; and 4) the *Primary Care Mental Health Interface Project*, involves on-site psychiatric consultation liaison services at both primary and pediatric care settings.

Lastly, an intensive planning effort is underway to improve the system of services available to *Transition Age Youth* (ages 16-24) involving collaboration across age divisions within mental health, as well as with representatives from local shelters, housing, and community college programs.

***The Continuum of Mental Health Services.***

1. **Prevention and Early Intervention Programs.** Impetus and funding for early mental health intervention in San Francisco derive from a variety of sources. Mental health consultation and early intervention services are provided through: (a) federally funded *Head Start* programs; (b) state funded *Primary Intervention Programs (PIP)*; (c) partnership in the planned San Francisco Unified School District (SFUSD) *Healthy Start* program; (d) interagency *Children's Amendment* programs, created through local voter initiative; (e) public health funded *Early and Periodic Screening, Diagnoses and Testing* of children and youth for mental health problems; and (f) funding from the Miriam and Peter Haas Fund for mental health consultation to childcare centers and strategic early childhood planning in a managed care environment.

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\* See attachment for a statement of CASSP principles and goals.

2. **Outpatient Mental Health Services.** Outpatient mental health services are a backbone of San Francisco's mental health service delivery system. San Francisco children, youth, and families are served by six child outpatient clinics and seven comprehensive outpatient clinics which serve children, youth and adult populations. Traditionally, outpatient services focus resources upon psychological testing, medication monitoring, and individual, couple, and family therapy. Over recent years, San Francisco's outpatient providers expanded their range of service offerings to include services provided in homes, schools, health centers, and day care facilities. Children, youth and parent support groups and parenting skills training are also available. Children, youth and parent support groups and parenting skills training are also available. As a matter of policy, all clinics: (a) accept children entering the mental health system through special education mandate (AB 3632); (b) respond to youth discharged from hospitals within 72 hours; (c) participate in early intervention and prevention programs; and, (d) are partners in school-based mental health programs for youth with serious emotional, behavioral, and mental health problems.
3. **Mental Health and School Partnerships.** Since the 1993-94 school year, the mental health department and the county school district work together to support teachers and other special education personnel to enhance the classroom experience and outcomes of special education youth with serious emotional disturbance (SED). Currently, 33 SED special day classrooms in 20 different schools throughout San Francisco are paired with mental health professionals from 13 different provider organizations. In the partnerships, mental health professionals provide a range of services including: (a) school-site clinical services (individual and group therapy and crisis intervention); (b) consultation with teachers and paraprofessionals; (c) mental health assessment and participation in student study team and individual education planning (IEP) meetings; and, (d) community outreach and services to parents.
4. **Primary Care and Mental Health Interface.** As part of the managed care implementation, the Primary Care/Mental Health Interface Project was initiated to provide on-site psychiatric and psychosocial consultations to primary pediatric care providers (family practitioners, nursing staff, social workers and other ancillary clinical staff) at community based health centers throughout San Francisco by a team of a child psychiatrist/pediatrician and a licensed psychiatric social worker. Over the years, through innovative delivery of outpatient mental health services in neighborhood based satellite health/mental health clinics, it has been observed that families are more inclined to express psychosocial issues to their primary care providers due to comfort and trust. As part of a system of care that is family oriented, consumer driven, strength based and supports the integration of coordinated care between different children's systems of care, this new initiative has provided significant prevention and early intervention and comprehensive treatment to children, youth and their families as well as accessibility to mental health services through health settings. This is more critical with implementation of managed care and Healthy Families.
5. **Family Involvement Program.** A Family Involvement Team, comprising of parents whose children/youth have been or are receiving mental health and other related services, was established to build solid partnerships between parents, caregivers and children's systems of care. Embedded in this partnership is helping families recognize their strengths, supporting family growth and involving families in designing, implementing and evaluating services, and policy making. As part of its belief to empower families to help their children reach their greatest potential, the Team will provide one on one family support, mentoring, outreach, information and referral, educational workshops and "bridging services" between different children's systems of care, e.g. school, child welfare, juvenile probation and substance abuse. Additionally, the Team will provide family focused presentations and trainings.
6. **Day Treatment Programs.** Mental health day treatment programs are appropriate when less structured and time intensive services are not sufficient, or as a step toward community living for children and youth leaving the hospital or residential treatment environment. Day treatment is

typically integrated with a non-public school placement for children or youth who may be living at home, with foster parents, or in group care. Most San Francisco day treatment programs serve children who are eligible for special education services due to serious emotional disturbance (SED). There are approximately 90 youth in day treatment programs at any one time in San Francisco. The children and youth may be living at home, in group homes or residential treatment, or with foster parents at the time of program involvement. For youth in non-public school placement, the service day is structured around morning classes, with clinical staff available for support, and individual therapy. Afternoon programs typically include additional individual therapy, along with group therapy sessions, and family counseling.

7. **Mental Health Crisis Teams.** The *Comprehensive Child Crisis Service* provides 24-hour response to any child or youth in San Francisco undergoing a mental health crisis. The service evaluates children during crisis in home, school, or treatment settings for assaultiveness, suicidality, agitation, absence of behavior control, psychosis, or severe depression. The crisis team functions as a gatekeeper into hospital services and coordinates closely with shelter and placement agencies for youth in need of these alternatives. A second mental health assessment and crisis team provides 24-hour response, screening, and appropriate mental health referral to any child or adolescent who may have been a victim of sexual abuse. Many of the children are in short term shelter care and may be entering or are at-risk of foster care placement. The team is housed at the San Francisco General Hospital within a sexual abuse resource agency, the *Child and Adolescent Sexual Abuse Resource Center*.
8. **Intensive Case Management Services.** The *Family Mosaic Project* provides intensive case management of children and youth who are traditional users of restrictive, institutional types of care. The project focuses interagency teams of multi-agency human service providers (called Family Advocates) to re-connect children and youth coming from restrictive levels of care to home, school, and community-based services. Capitation of expenditures and managing the care of clients in residential and subacute treatment facilities is a central feature of the *Family Mosaic Project*. Daily intervention is also extended to children and youth who are at high risk of out-of-home placement in an effort to avoid such placement. Upon enrollment into the *Family Mosaic Project*, each child receives a comprehensive assessment that includes a mental status examination, educational, health, and home environment screens, and a risk assessment. The information gathered is used to develop a plan of care in partnership with the family. It is the Family Advocate's responsibility to access, broker, authorize payment, and coordinate the services specified on the plan of care. The *Family Mosaic Project* is similar to other ecologically valid programs nation-wide that use multi-systemic family intervention and/or wrap-around approaches in working with complex needs children, youth, and families to produce desirable outcomes.
9. **Hospitalization and Post-Hospitalization Transition Services.** Children and youth are hospitalized when medical necessity is established and upon public (Medi-Cal) or private insurance authorization of funding for hospitalization. Mental health department staff coordinate and authorize all acute and partial hospitalizations, lengths of stay, and transition services from the hospital. During hospitalization, mental health department staff conduct bi-weekly chart reviews to determine medical necessity for continued hospitalization and to commence with discharge and transition planning. Strict timelines for justifying involuntary admissions and for discharge planning must be adhered to in accordance with state law. Discharge and transition options include release to family home, foster care, or group home care with mental health support -- e.g., outpatient therapy, day treatment, intensive case management, in-home support, respite services, and wrap-around services. Partial hospitalization (day treatment in a hospital setting) is a service available as a transition from, or for avoidance of, acute inpatient care.
10. **Residential and Subacute Treatment Programs.** Residential treatment programs are privately run facilities that combine residential, educational, and clinical services in one setting. Numerous residential treatment programs operate throughout the greater Bay Area and are used

by San Francisco Mental Health. Residential treatment programs are licensed through the *State Department of Social Services* community care licensing of group homes. Clients with mental health needs might be placed in residential treatment programs by the *Department of Social Services*, the *San Francisco Unified School District* special education and mental health AB 3632 program, or the *Juvenile Probation Department*. The care provided in subacute facilities includes 24-hour residency, non-public school education, and intensive diagnostic, evaluation, therapeutic and medical/psychiatric services. In contrast to other residential treatment programs, subacute providers command additional mental health funding for their greater mental health treatment costs.

***Quality Management and Quality Assurance.*** Administrative oversight and management of the quality of children's mental health services occur at division and program levels through an interconnected network of administrators and committees. Central among them is the *Children's Quality Improvement Committee* (CQIC) which is currently focused upon (among other items): (a) articulation of typical pathways of care and associated principles and standards; and, (b) planning of enhanced monitoring of foster care, residential, and subacute services. The CQIC is supported by a subcommittee structure that engages additional program and administrative staff in quality assurance, intensive case management quality assurance, policy coordination, and system of care evaluation activities. Quality assurance (Q.A.) at the program level is overseen by a team headed by the children's division Medical Director. The team provides clinical direction to *Program Utilization Review and Quality Committees* (PURQ's) including : (a) consultation regarding diagnostic, acuity, and health status issues; (b) monitoring psychotropic medications for children and adolescents; (c) determining medical necessity for treatment at different levels of care; and, (d) evaluation and recommendations regarding critical incidents.

***Service System Evaluation.*** Criteria for service system evaluation in San Francisco stem directly from service system principles and goals as put forth in mental health planning documents and articulated by mental health administrators. The evaluation process is consistent with state mandates and protocols for data collection and embodies a set of core principles: the use of standardized instruments; the value of multiple perspectives upon a child's behavior; measurement over time and program involvement; age, gender, and linguistic appropriateness of the measurement tools; and, minimization of respondent burden. Rates and changes over time (e.g., at entrance to service, annually, and/or at exit) for service system outcomes are measured for psychiatric symptoms and behavior problems, adaptive functioning and social competency, school attendance and achievement, out-of-home placements, hospital and residential care, and juvenile probation involvement. San Francisco has high foster care utilization and increasing hospitalization rates; however, when case management is applied, out-of-home placements, hospitalizations, and juvenile recidivism decline. A number of data reports are available regarding these and related outcomes.

## **CASSP System of Care Values and Principles<sup>1</sup>**

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to adult service systems as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

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<sup>1</sup> From Stroul, B. & Freidman, R. (1986) *A System of Care for Severely Emotionally Disturbed Children & Youth*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, p.vii.

# Demographic Detail of Child Mental Health Clients (FY '96-'97)

	Ages 0-5		Ages 6-9		Ages 10-12		Ages 13-19		Eth Grp Sum	Eth Grp %
	Male	Female	Male	Female	Male	Female	Male	Female		
African American	63	97	165	101	274	167	467	329	1663	37.6%
Cambodian	2	2	5	4	9	5	17	9	53	1.2%
Chicano	11	15	14	17	26	17	57	45	202	4.6%
Chinese	73	45	63	19	57	32	109	82	480	10.9%
Filipino	5	6	6	3	23	9	26	25	103	2.3%
Hispanic	13	12	23	7	42	16	27	27	167	3.8%
Japanese	0	0	1	0	2	6	2	1	12	0.3%
Korean	0	0	1	0	2	3	17	5	28	0.6%
Laotian	0	0	0	1	1	1	7	2	12	0.3%
Latin	26	15	33	25	40	38	164	100	441	10.0%
Middle Eastern	0	1	1	0	3	2	4	6	17	0.4%
Multiple	19	26	11	12	16	13	42	49	188	4.3%
Native American	2	2	4	1	4	1	7	15	36	0.8%
Other Asian	1	0	1	0	3	1	8	11	25	0.6%
Other Non-White	2	2	9	4	24	13	29	9	92	2.1%
Other South Asian	0	0	0	2	0	0	1	3	6	0.1%
Pacific Islander	2	4	3	2	3	4	15	8	41	0.9%
Russian	1	0	2	0	4	3	6	6	22	0.5%
Unknown	1	1	5	4	12	6	49	23	101	2.3%
Vietnamese	8	9	8	7	8	4	36	11	91	2.1%
White	39	27	50	23	101	62	186	159	647	14.6%
<b>GndrXAgeGrp</b>	<b>268</b>	<b>264</b>	<b>405</b>	<b>232</b>	<b>654</b>	<b>403</b>	<b>1276</b>	<b>925</b>	<b>4427</b>	<b>100.2%</b>
	<b>6.1%</b>	<b>6.0%</b>	<b>9.1%</b>	<b>5.2%</b>	<b>14.8%</b>	<b>9.1%</b>	<b>28.8%</b>	<b>20.9%</b>	<b>100.0%</b>	
<b>Age Grp Sum</b>	<b>0-5:</b>	<b>532</b>	<b>6-9:</b>	<b>637</b>	<b>10-12:</b>	<b>1057</b>	<b>13-19:</b>	<b>2201</b>		
		<b>12.0%</b>		<b>14.4%</b>		<b>23.9%</b>		<b>49.7%</b>		
<b>Gndr Grp Sum</b>	<b>Male:</b>	<b>2603</b>	<b>Female:</b>	<b>1824</b>						
		<b>58.8%</b>		<b>41.2%</b>						

**COMMUNITY MENTAL HEALTH  
SERVICES CLIENTS,  
AGES 0-19, BY ZIP CODE OF RESIDENCE,  
FY 1996/97**

<u>Zip Code</u>	<u>Neighborhood</u>	<u>#</u>	<u>%</u>
94124	Bayview Hunters Point	496	11.2%
94110	Mission District	490	11.1%
94112	Excelsior	357	8.1%
94134	Visitacion Valley	273	6.2%
94102	Civic Center	159	3.6%
94115	Fillmore/Western Add'n	150	3.4%
94122	Inner Sunset	125	2.8%
94121	Outer Richmond	124	2.8%
94133	Telegraph Hill	108	2.4%
94117	Haight Ashbury	103	2.3%
94109	Russian/Nob Hill	98	2.2%
94116	Outer Sunset	95	2.1%
94118	Inner Richmond	83	1.9%
94103	South of Market	77	1.7%
94132	Lake Merced	70	1.6%
94108	Chinatown	52	1.2%
94131	Diamond Heights	51	1.2%
94107	Potrero Hill	45	1.0%
-	Other	333	7.5%
-	Unknown	1,138	25.7%
<b>TOTAL</b>		<b>4,427</b>	<b>100.0%</b>

Source: San Francisco Department of Public Health, Community Mental Health Services

Note: Also refer to the map, "San Francisco Children's Mental Health Caseload, FY 1996-97" showing rate per 1,000 children for ages 9-17 (n=4,451 clients).

# SF Children's Mental Health Caseload: FY 1996-97

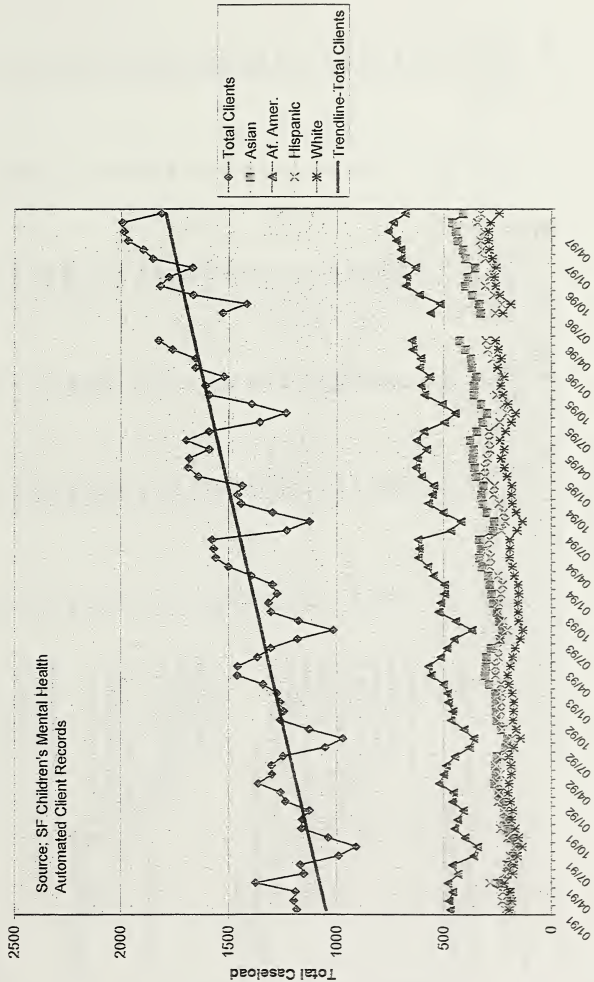
Rate per 1000 children ages 9-17

- ☒ Over 70
- ☐ 60 to 70
- ☐ 50 to 60
- ☐ 30 to 50
- ☐ Under 30

n=4,451 Clients  
929: no address  
183: outside city  
3,247 geocoded  
82 not geocodable



## Open Caseload: SF Children's Mental Health Services



## Breakdown of Primary Diagnoses<sup>1</sup> of Child and Youth Clients

### Diagnostic Group & Diagnosis

#### Disorders Usually First Diagnosed In Infancy, Childhood, or Adolescence

Autism  
Pervasive Developmental Disorder  
Separation Anxiety  
Conduct Disorder  
Disruptive Behavior Disorder NOS  
Oppositional Defiant Disorder  
Reactive Attachment Disorder  
Attention Deficit Hyperactivity Disorder  
Learning Disorders  
All Other Disorders in Diagnostic Group  
Schizophrenia & Related Disorders

#### Mood Disorders

Major Depression  
Bipolar Disorder  
Dysthymic Disorder  
All Other Mood Disorders

#### Anxiety Disorders

Generalized Anxiety Disorder  
Post Traumatic Stress Disorder  
All Other Anxiety Disorders

#### Adjustment Disorders

w/ Depressed Mood  
w/ Mixed Disturbance of Emotions & Conduct  
Unspecified Type  
All Other Adjustment Disorders

#### Other Conditions ... Focus of Clinical Attention (e.g., V-Codes & child maltreatment)

#### All Other Diagnoses

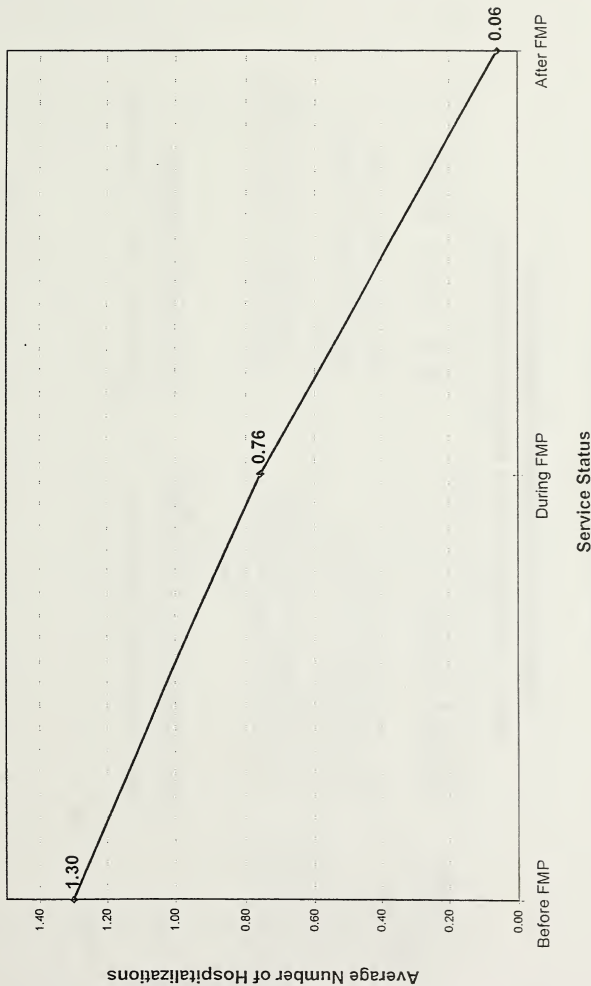
#### Deferred/Missing Diagnoses

*CheckSum (Broad Diagnostic Groups):*

Diagnostic Group & Diagnosis	Number of Total Clients (0-19 yrs.)	Percent of Clients (0-19 yrs.)	Number of Child Clients (0 - 12 yrs.)	Percent of Child Clients (0 - 12 yrs.)	Number of Youth Clients (13- 19 yrs.)	Percent of Youth Clients (13- 19 yrs.)
<b>Disorders Usually First Diagnosed In Infancy, Childhood, or Adolescence</b>	<b>1,340</b>	<b>30.3%</b>	<b>840</b>	<b>37.7%</b>	<b>500</b>	<b>22.7%</b>
Autism	30	.7%	27	1.2%	3	.1%
Pervasive Developmental Disorder	43	1.0%	35	1.6%	8	.3%
Separation Anxiety	37	.8%	33	1.5%	4	.2%
Conduct Disorder	258	5.8%	26	1.2%	232	10.5%
Disruptive Behavior Disorder NOS	62	1.4%	45	2.0%	17	.8%
Oppositional Defiant Disorder	507	11.5%	346	15.6%	161	7.3%
Reactive Attachment Disorder	26	.6%	25	1.1%	1	..
Attention Deficit Hyperactivity Disorder	258	5.8%	204	9.2%	54	2.4%
Learning Disorders	42	.9%	37	1.7%	5	.2%
All Other Disorders in Diagnostic Group	77	1.7%	62	2.8%	15	6.8%
<b>Schizophrenia &amp; Related Disorders</b>	<b>81</b>	<b>1.8%</b>	<b>13</b>	<b>.6%</b>	<b>68</b>	<b>3.1%</b>
<b>Mood Disorders</b>	<b>904</b>	<b>20.4%</b>	<b>384</b>	<b>17.2%</b>	<b>520</b>	<b>23.6%</b>
Major Depression	207	4.7%	30	1.3%	177	8.0%
Bipolar Disorder	23	.5%	6	.3%	17	.8%
Dysthymic Disorder	527	11.9%	283	12.7%	244	11.1%
All Other Mood Disorders	147	3.3%	65	2.9%	82	3.7%
<b>Anxiety Disorders</b>	<b>417</b>	<b>9.4%</b>	<b>278</b>	<b>12.5%</b>	<b>139</b>	<b>6.3%</b>
Generalized Anxiety Disorder	86	1.9%	68	3.1%	18	.8%
Post Traumatic Stress Disorder	264	6.0%	160	7.2%	104	4.7%
All Other Anxiety Disorders	67	1.5%	50	2.2%	17	.8%
<b>Adjustment Disorders</b>	<b>955</b>	<b>21.6%</b>	<b>280</b>	<b>12.6%</b>	<b>675</b>	<b>30.7%</b>
w/ Depressed Mood	226	5.1%	39	1.8%	187	8.5%
w/ Mixed Disturbance of Emotions & Conduct	257	5.8%	99	4.4%	158	7.2%
Unspecified Type	237	5.3%	42	1.9%	195	8.9%
All Other Adjustment Disorders	235	5.3%	100	4.5%	135	6.1%
<b>Other Conditions ... Focus of Clinical Attention (e.g., V-Codes &amp; child maltreatment)</b>	<b>344</b>	<b>7.8%</b>	<b>257</b>	<b>12.4%</b>	<b>87</b>	<b>3.0%</b>
<b>All Other Diagnoses</b>	<b>134</b>	<b>3.0%</b>	<b>39</b>	<b>1.7%</b>	<b>95</b>	<b>4.3%</b>
<b>Deferred/Missing Diagnoses</b>	<b>252</b>	<b>5.7%</b>	<b>135</b>	<b>6.1%</b>	<b>117</b>	<b>5.3%</b>
<i>CheckSum (Broad Diagnostic Groups):</i>	<i>4,427</i>	<i>100%</i>	<i>2,226</i>	<i>100%</i>	<i>2,201</i>	<i>100%</i>

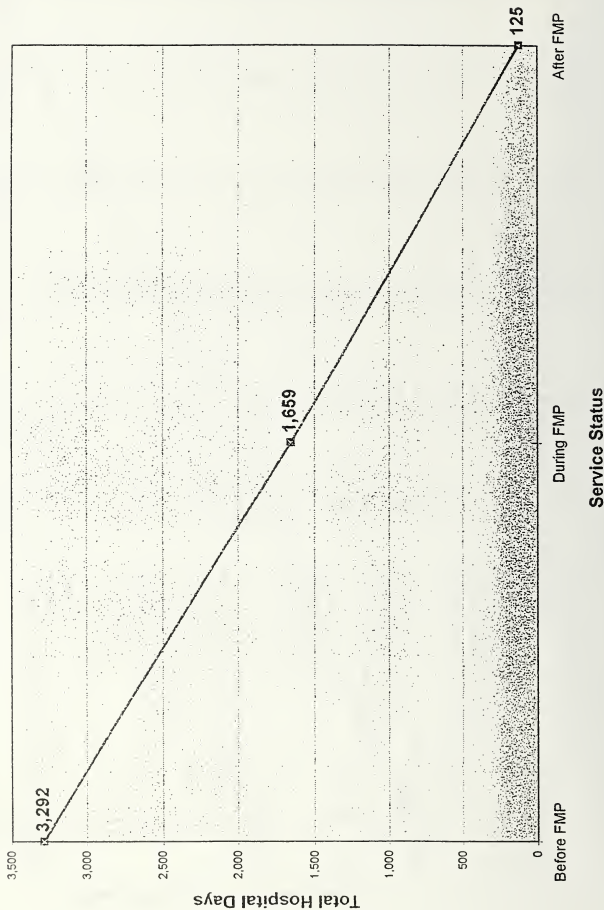
<sup>1</sup> Primary (first listed) DSM IV Axis I diagnoses made at entry into services with the most continuous provider during FY '96-'97. The episode of care with the provider may have begun prior to the focal fiscal year.

## Psychiatric Inpatient Hospitalizations Before, During and After Program Involvement



Based on 184 FMP clients with hospitalizations. Time periods compared are one year prior to FMP enrollment, time during the program (average of 14 months), and up through one year after discharge.

## Total Days of Psychiatric Hospitalization Before, During and After Program Involvement



Based on 184 FMP clients with hospitalizations. Time periods are one year prior to FMP enrollment, time during the program (average of 14 months) and up through one year after discharge.

\*

# INPATIENT COST SAVINGS

**Savings During Program  
Enrollment ( $\bar{x}$  = 14 Months)**

**Savings Over 12 Months  
Following Program**

Reductions in  
Hospital Days  
Compared to  
the Year  
Preceding  
FMP  
Enrollment

3,292 Hospital Days Before Program  
1,659 Hospital Days During Program  
-----  
1,633 Less Days In Hospital  
@ \$550 Cost Per Day

3,292 Hospital Days Before Program  
125 Hospital Days After Program  
-----  
3,167 Less Days In Hospital  
@ \$550 Cost Per Day

**\$898,150** over 14 months

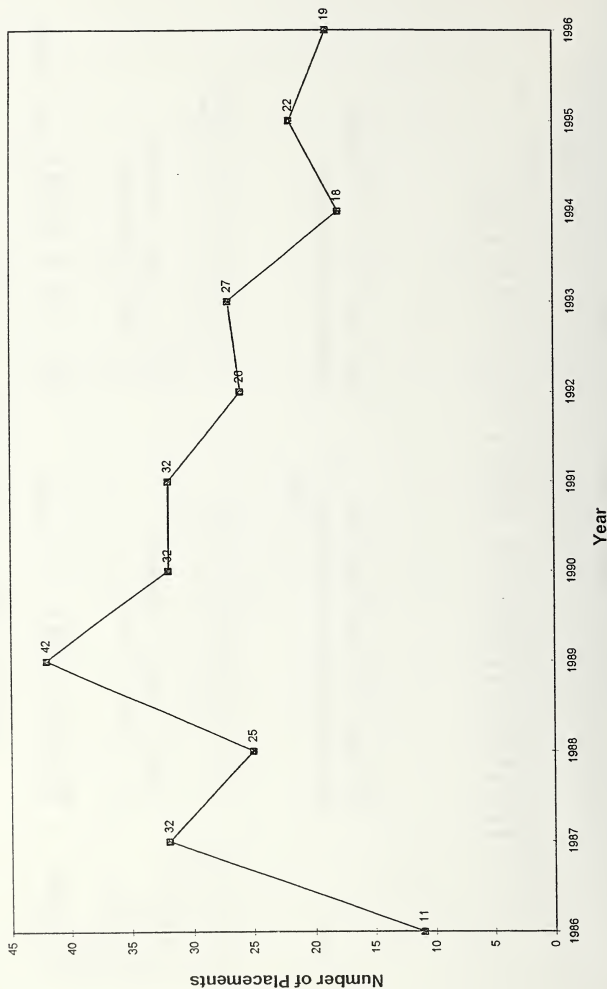
**\$1,741,850** over 12 months

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\* Savings calculated on 184 clients with hospitalizations before, during, and/or after program enrollment.

*Family Mosaic Project Outcomes*

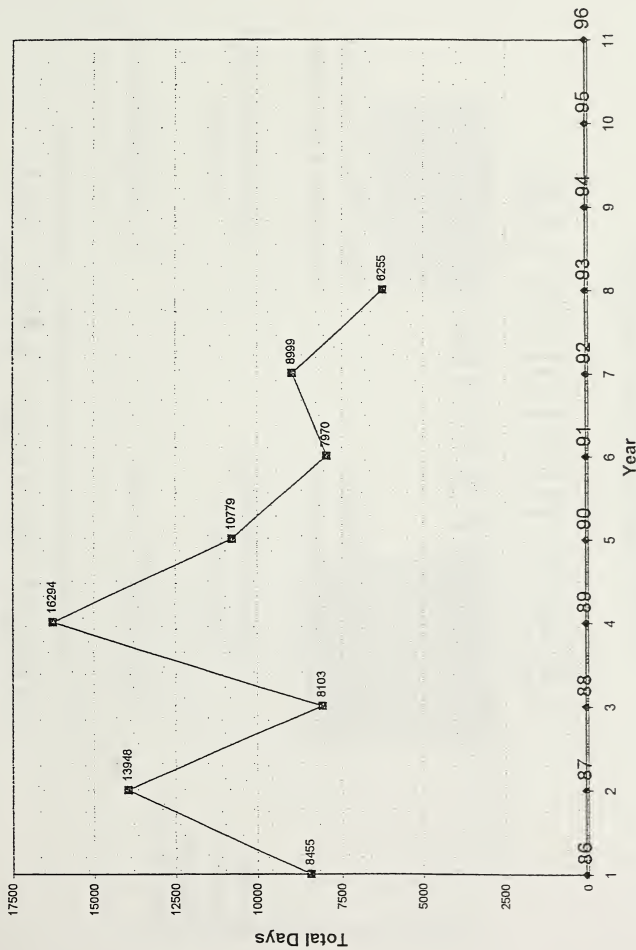
**Annual Number of AB 3632 Residential Placements**



FMP case management of AB 3632 funded placements in residential treatment settings began in 1990. Analyses based on 196 AB 3632 clients served in residential care over an eleven year period.

*Family Mosaic Project Outcomes*

**Total Days in AB 3632 Residential Treatment**



FMP case management of AB 3632 funded residential placements began in 1990. Analyses based on 165 clients over eight years. Data (exit dates) currently incomplete for 1994-96.

# AB 3632 RESIDENTIAL \* COST SAVINGS

	Four Years Before Program Inception	First Four Years of Program Operation
Average Number of Placement Days Per Year	11,700 Placement Days <i>at a cost of</i>	8,501 Placement Days <i>at a cost of</i>
	\$1,800,877 per year	\$1,308,483 per year

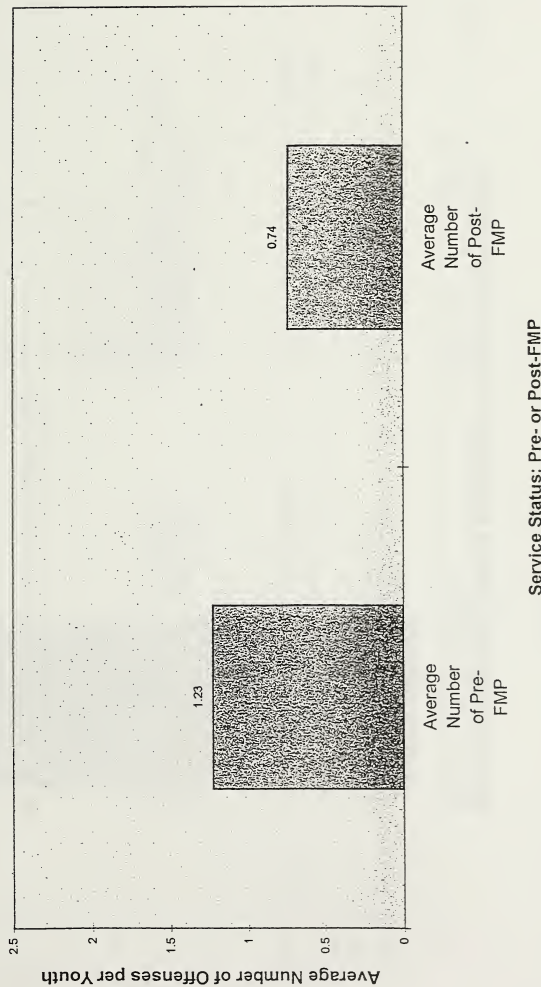
**Annual Savings: \$492,394**

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\* Savings calculated on 165 AB 3632 clients served in Level 12 and 14 residential treatment programs from 1986 to 1994. The ratio of clients served is 2:1 in Level 12 to Level 14 at a daily cost of \$127.43 for Level 12 care and \$167.10 for Level 14.

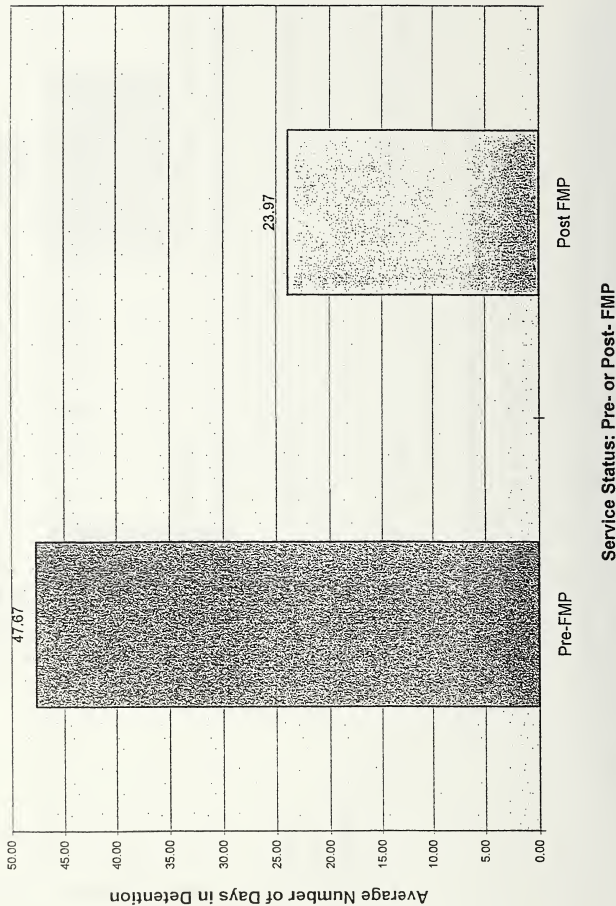
## *Family Mosaic Project Outcomes*

### **Criminal Offenses Before and After Program Involvement**



*Family Mosaic Project Outcomes*

**Days in Detention Before and After Program Involvement**



# JUVENILE DETENTION COST \* SAVINGS

## Savings During Program Enrollment (N = 14 Months)

Reductions in  
Days In Juvenile  
Detention  
-----  
17,592 Detention Days Before Program  
5,734 Detention Days During Program  
-----  
11,858 Less Days In Detention  
@ \$239 Cost Per Day

**\$2,834,062** over 14 months

## Savings Over 12 Months Following Program

17,592 Detention Days Before Program  
4,554 Detention Days After Program  
-----  
13,038 Less Days In Detention  
@ \$239 Cost Per Day

**\$3,116,082** over 12 months

---

\* Savings calculated on 193 FMP clients with detentions before, during, and/or after program enrollment.

**Families in San Francisco Family Shelters,\*  
Last Home - San Francisco Neighborhood,  
July 1995 - June 1997**

<u>Neighborhood</u>	<u>#</u>	<u>%</u>
Tenderloin	74	21%
Bayview Hunters Point	61	17%
Mission	55	16%
Western Addition	48	14%
Haight	34	10%
Potrero	17	5%
OMI (Ocean/Merced/Ingleside)	12	3%
Sunset	10	3%
Visitacion Valley	10	3%
Bernal Heights	9	3%
Excelsior	5	1%
Richmond	4	1%
South of Market	4	1%
Glen Park	3	1%
Chinatown	1	<1%
Noe Valley	1	<1%
North Beach	1	<1%
Total	349	100%

\*Note: Includes 4 of the largest family shelters - Compass, Hamilton, Rafael, and Richmond Hills.

Source: San Francisco Department of Human Services,  
Family Survey Statistics, 7/1/95 to 6/30/97

JUVENILE MISDEMEANOR ARRESTS,  
BY GENDER AND OFFENSE,  
SAN FRANCISCO, 1987-1996

GENDER AND OFFENSE	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
JUVENILE MISDEMEANOR ARREST	4,115	3,522	2,731	2,410	2,432	2,260	2,581	2,296	1,829	2,081
MALE	3,174	2,780	1,937	1,774	1,725	1,739	1,849	1,633	1,285	1,378
FEMALE	941	742	794	636	707	521	732	663	544	703
MANS-VEH										
ASSAULT AND BATTERY	282	438	416	383	350	289	316	264	277	250
PETTY THEFT	626	707	657	662	772	593	676	515	412	611
OTHER THEFT	4	5	5	11	16	9	5	7	10	5
CK/ACC CARDS	1	3		2	1	6	2	4		1
MARIJUANA	103	87	74	61	39	46	58	57	54	65
OTHER DRUGS	65	48	33	34	14	11	24	23	16	27
INDECENT EXPOSURE	3	3		1	5	1	7			
ANNOYING CHILDREN			2	2				3	1	
OBSCENE MATTER				1						
LEWD CONDUCT	40	38	13	10	29	17	5	10	4	4
PROSTITUTION	21	23	19	8	14	28	39	36	24	36
CONT DEL MINOR			1							
DRUNK	21	10	6	8	15	5	13	3	6	4
LIQUOR LAWS	68	56	65	26	22	15	26	40	24	27
DISORDERLY CONDUCT *	17	44	18	8	16	13	15	11	22	6
DISTURBING THE PEACE	76	75	92	61	64	90	66	67	39	29
VANDALISM	434	436	222	194	198	272	322	238	190	156
MALICIOUS MISCHIEF	72	55	43	58	51	32	36	28	30	21
TRESPASSING	130	119	116	89	106	74	84	79	67	60
WEAPONS	30	44	37	50	77	73	55	38	31	26
DRIVE UNDER INFLUENCE	14	9	10	14	13	7	5	12	6	6
INH-AND-RUN	16	11	3	5	11	9	6	8	4	9
SELECTED TRAFFIC VIOLATIONS	16	12	15	19	8	11	6	16	12	10
JOY RIDING	11	17	26	55	35	22	24	19	34	37
GAMBLING										
NONSUPPORT	3	2	6	10	6	11	9	14	1	11
GLUE SNIFFING										
CITY/COUNTY ORDINANCE	2			1	1		1		1	7
FTA-NON TRAFFIC	70	374	445	318	63	41	51	42	42	39
OTHER	29	16	9	23	58	78	82	81	60	60
	1,961	888	398	295	448	507	648	681	461	574
STATUS OFFENSES	789	1,066	496	176	145	81	80	58	104	63
POP AGE 10 THRU 17 (THOUSANDS)	55.8	53.0	50.6	49.9	50.0	50.4	49.8	49.5	49.4	49.5

JUVENILE FELONY ARRESTS,  
BY GENDER AND OFFENSE,  
SAN FRANCISCO COUNTY, 1987-1996

GENDER AND OFFENSE	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
JUVENILE FELONY ARRESTS	2,205	2,829	2,852	2,537	2,399	2,259	2,553	2,477	2,338	2,366
MALE	1,990	2,557	2,542	2,269	2,123	1,979	2,228	2,072	1,947	2,059
FEMALE	215	272	310	268	276	280	325	405	391	507
VIOLENT OFFENSES	388	453	548	570	435	527	766	830	885	887
HOMICIDE *	9	8	7	13	18	17	34	14	8	8
FORCIBLE RAPE	9	6	8	10	9	6	6	3	14	11
ROBBERY	114	188	260	303	168	258	458	527	545	496
ASSAULT *	252	248	272	238	236	243	256	281	315	362
KIDNAPPING	4	3	1	6	4	3	12	5	3	10
PROPERTY OFFENSES	862	1,197	1,203	1,263	1,287	1,124	1,056	866	778	860
BURGLARY	216	313	266	273	335	369	303	284	261	265
THEFT	130	130	117	159	146	142	129	112	123	146
MOTOR VEHICLE THEFT	506	727	800	802	784	582	601	445	366	420
FORGERS/ACC CARDS	9	10	11	9	14	12	13	13	8	16
ARSON	1	17	9	20	8	19	10	12	20	13
DRUG OFFENSES	704	929	906	527	507	437	504	571	484	589
NARCOTICS	601	854	825	434	413	334	406	491	358	473
MARIJUANA	76	50	54	72	68	93	90	64	107	95
DANGEROUS DRUGS	24	20	25	16	20	8	6	10	18	15
OTHER	3	5	2	5	6	2	2	6	1	6
SEX OFFENSES	25	18	22	21	28	23	34	11	20	15
LEWD OR LASCIVIOUS	16	8	14	5	8	13	12	5	7	6
OTHER	9	10	8	16	20	10	22	6	13	9
OTHER OFFENSES	226	232	173	156	142	148	193	199	171	215
WEAPONS	53	58	68	44	64	45	84	70	60	71
DRIVE UNDER INFL.	2		2					1	1	2
HIJ-AND-RUN	6	6	5	3	7	7	6	4	7	5
ESCAPE	1	2	1	3	1		4	1		
BOOKMAKING	1				1					
OTHER	163	166	97	104	69	96	99	123	103	137
POPULATION AGE 10 THRU 17 (THOUSANDS)	55.8	53.0	50.6	49.9	50.0	50.4	49.8	49.5	49.4	49.5

Homicide and Assault: Assault with intent to commit murder is included in some homicide statistics because of a 1981 law that repealed Penal Code Section 217.  
 Assault: A law change in 1986 required reporting domestic violence incidents as criminal conduct.

# CRIMES INVOLVING JUVENILES: 1996

## Planning Area Boundaries

### Youth-related Crime Location



**n = 12,803 (85% geocodable)**

SOURCE: SFPD RMS

Prepared by Resource Development Associates

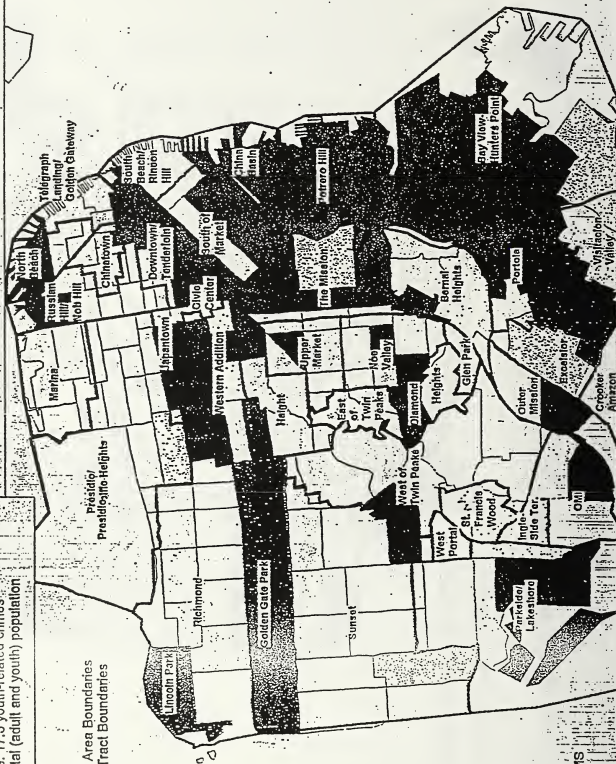
## by census tract: 1996

by census tract: 1996

- ☐ More than 40% over city average  
☐ 20% - 40% over city average  
☐ Within 20% of city average  
☐ 20% - 40% under city average  
☐ More than 40% under city average

City Average: 17.3 youth-related crimes per 1,000 total (adult and youth) population

Planning Area Boundaries  
Census Tract Boundaries



n = 12,803 SOURCE: SFPD RMS

## Persistent Youth Crime Hotspots in San Francisco: 1993-1996

A "hotspot" was defined as a face block with 6 or more crimes with youth involvement per year in each year between 1993 and 1996.

—Between 1993 and 1996, San Francisco had 53,599 youth-related crimes, of which 45,378 (85%) were geocodable.

—Of San Francisco's 15,937 blocks, 6,142 had a geocodable youth crime during this period.

—138 blocks counted as persistent crime hotspots—less than 1% of all blocks. These 138 blocks tallied 13,918 youth-related crimes during this period, 30.7% of all geocodable youth-related crimes.



**MEDI-CAL ELIGIBLES,\***  
**AGES 0-20 (BY SINGLE YEARS OF AGE),**  
**SAN FRANCISCO AND CALIFORNIA,**  
**OCTOBER 1996**

Age	San Francisco		California	
	#	%	#	%
<1	3,015	7.3%	222,626	7.4%
1	2,565	6.2%	214,032	7.1%
2	2,655	6.4%	208,361	6.9%
3	2,526	6.1%	204,846	6.8%
4	2,551	6.2%	200,984	6.7%
5	2,391	5.8%	196,240	6.5%
6	2,234	5.4%	181,453	6.0%
7	2,164	5.2%	163,866	5.5%
8	1,895	4.6%	152,342	5.1%
9	1,870	4.5%	140,531	4.7%
10	1,756	4.3%	132,470	4.4%
11	1,640	4.0%	126,215	4.2%
12	1,674	4.1%	118,596	3.9%
13	1,623	3.9%	111,985	3.7%
14	1,605	3.9%	109,786	3.7%
15	1,668	4.0%	106,290	3.5%
16	1,668	4.0%	101,832	3.4%
17	1,718	4.2%	94,769	3.2%
18	1,467	3.6%	78,272	2.6%
19	1,273	3.1%	70,065	2.3%
20	1,350	3.3%	69,657	2.3%
Total, 0-20	41,308	100.0%	3,005,218	100.0%
% of Total	35.5%	-	56.1%	-
Total, All Ages	116,451	-	5,359,001	-

Source: California Dept. of Health Services, "Advance Report Table 1, Medi-Cal Program, Persons Certified Eligible By County, Sex, and Age, Total Both Sexes, October 1996", MEDS Monthly Extract File (MEF) (run date 4/24/97) ([www.dhs.cahwnet.gov](http://www.dhs.cahwnet.gov))

\* Note: "Eligibles" are individuals who have been determined eligible for Medi-Cal benefits.  
Note: Includes prepaid health plans, fee-for-service, and county organized health systems.

**MEDI-CAL ELIGIBLES,\* ALL AGES,  
BY ZIP CODE AND AID CATEGORY GROUPS,  
SAN FRANCISCO AND CALIFORNIA, JANUARY 1997**

ZIP CODE	All Ages			Children/Youth Only					SUBTOTALS				TOTAL, All Aid Categories		
	PA AFDC	MN AFDC	MI Youth	100% Pov'	200% Pov'	133% Pov'	185% Pov'	#	Selected		#	Row %	Other		# Col %
<b>NEIGHBORHOOD</b>															
94102 Tenderloin/Civic Center	2,061	398	121	15	0	70	55	2,720	32%	2,720	5,864	68%	8,584	79%	
94103 South of Market	1,249	352	160	25	0	67	55	1,908	33%	1,908	3,842	67%	5,750	5%	
94105/7 Rincon/Potrero Hill	1,234	141	32	4	0	7	16	1,434	46%	1,434	1,707	54%	3,141	3%	
94108 Chinatown	270	173	122	13	0	42	35	655	27%	655	1,765	73%	2,420	2%	
94109 Park/Russian Hill	1,377	497	261	16	0	98	107	2,356	36%	2,356	4,153	64%	6,509	6%	
94110 Inner Mission	3,689	1,475	723	81	4	408	324	6,704	54%	6,704	5,696	46%	12,400	11%	
94112 Ingleside-Excelsior	3,021	1,204	503	3	1	232	269	5,233	49%	5,233	5,448	51%	10,681	9%	
94114 Castro, Noe Valley	144	61	23	1	0	6	17	252	21%	252	940	79%	1,192	1%	
94115 Western Addition	2,093	297	61	5	0	26	27	2,509	44%	2,509	3,192	56%	5,701	5%	
94116 Parkside	987	423	111	13	0	37	45	1,616	34%	1,616	3,165	66%	4,781	4%	
94117 Ingle-Ashbury	999	168	62	2	0	26	28	1,285	41%	1,285	1,828	59%	3,113	3%	
94118 Inner Richmond	1,188	382	96	10	0	37	48	1,761	45%	1,761	2,156	55%	3,917	3%	
94121 Outer Richmond	1,803	485	78	24	1	42	60	2,493	48%	2,493	2,708	52%	5,201	5%	
94122 Sunset	1,528	497	144	23	2	56	65	2,315	44%	2,315	2,923	56%	5,238	5%	
94123 Marina	46	39	2	1	0	1	6	95	31%	95	211	69%	306	<1%	
94124 Bayview-Juiter's Point	6,005	745	226	21	0	100	71	7,168	71%	7,168	2,891	29%	10,059	9%	
94127 St. Fr's W/UMiraf/Seaside	149	70	30	3	0	5	7	264	31%	264	588	69%	852	1%	
94130 Treasure Island	3	1	40	0	0	0	0	44	75%	44	15	25%	59	<1%	
94131 Twin Peaks-Glen Park	371	111	40	2	1	11	20	556	45%	556	687	55%	1,243	1%	
94132 Lake Merced	702	182	56	10	0	27	39	1,016	51%	1,016	969	49%	1,985	2%	
94104/11/33 Financial/Telegraph/N. Beach/Clayton	982	441	229	28	0	98	87	1,865	33%	1,865	3,822	67%	5,687	5%	
94134 Vista/Union Valley	3,203	784	246	35	1	121	127	4,517	62%	4,517	2,722	38%	7,239	6%	
SUBTOTAL, Residential	33,104	8,926	3,366	335	10	1,517	1,508	48,766	46%	48,766	57,292	54%	106,058	93%	
SUBTOTAL, Other	2,410	740	740	2	1	11	28	4,490	53%	4,490	4,009	47%	8,499	7%	
TOTAL	35,514	10,224	4,106	337	11	1,528	1,536	53,256	-	53,256	61,301	-	114,557	100%	
% of Total	31%	9%	4%	0%	0%	1%	1%	46%	-	-	54%	-	100%	-	
California	2,816,301	434,544	276,796	27,444	978	85,536	90,231	3,731,830			1,565,182		5,297,012		
% of Total	53%	8%	5%	<1%	2%	2%	2%	70%			30%		100%		

Source: California Dept. of Health Services, Medical Care Statistics Section, "Medi-Cal Eligibility By Zip Code Table", Medi-Cal Eligibility File, January 1997 ([www.dhs.ca.gov](http://www.dhs.ca.gov))

1) Zip codes less than 50 per county are categorized as "Other".

2) 94129 = Presidio, with a population of ages 0-18 of 1,477. Data on Medi-Cal eligibles for this zip code was not available.

"Other" zip codes include 94014, 94015, 94044, 94070, 94080, 94119, 94120, 94140, 94141, 94142, 94164, 94188, 94533, 94558, 94591, 94605, 94612, 94804, 94806, 94903. There were no eligibles identified within zip code 94129 (Presidio - population of ages 0-18 = 1,477).

3) "Eligibles" are individuals who have been determined eligible for Medi-Cal benefits.

**MEDI-CAL ELIGIBLES,\***  
**BY ZIP CODE AND SELECTED AGE CATEGORIES,**  
**SAN FRANCISCO AND CALIFORNIA, JANUARY 1997**

ZIP CODE	NEIGHBORHOOD	SUBTOTALS										TOTAL, ALL AGES			POPULATION, AGE 0-20		
		0-20					21+					TOTAL, ALL AGES			POPULATION, AGE 0-20		
		#	%	Col	Row	%	#	%	Col	Row	%	#	%	Col	#	%	M-Cal**
94102	Tenderloin/Civic Center	137	640	461	391	323	1,952	23%	5%	77%	8%	8,577	8%	4,196	3%	47%	
94103	South of Market	143	522	355	287	255	1,562	27%	4%	73%	5%	5,803	5%	3,254	2%	48%	
94105/7	Rincon/Potrero Hill	67	363	270	189	168	1,057	34%	3%	66%	3%	3,138	3%	2,346	2%	45%	
94108	Chinatown	44	177	94	68	66	449	19%	1%	81%	2%	2,419	2%	1,897	1%	24%	
94109	Pull/Russian Hill	148	532	341	280	342	1,643	25%	4%	75%	6%	6,495	6%	5,577	4%	29%	
94110	Inner Mission	552	2,129	1,293	891	869	5,734	46%	14%	65%	11%	12,393	11%	18,253	13%	31%	
94112	Ingleside-Inxelsior	439	1,360	884	736	651	4,070	38%	10%	62%	9%	10,717	9%	16,638	12%	24%	
94114	Castro, Noe Valley	19	63	48	26	21	177	15%	<1%	101%	1%	1,189	1%	2,773	2%	6%	
94115	Westside Addition	112	497	517	426	312	1,864	33%	5%	87%	5%	5,694	5%	4,123	3%	45%	
94116	Parkside	74	236	255	258	263	1,086	23%	3%	77%	4%	4,774	4%	8,227	6%	13%	
94117	Highgate-Ashbury	50	269	235	183	200	937	30%	2%	70%	3%	3,107	3%	5,495	4%	17%	
94118	Inner Richmond	71	239	220	273	295	1,098	28%	3%	72%	3%	3,913	3%	6,721	5%	16%	
94121	Outer Richmond	93	292	346	420	332	1,483	29%	4%	71%	5%	5,198	5%	7,527	5%	20%	
94122	Sunset	99	353	327	367	311	1,457	28%	4%	72%	5%	5,233	5%	10,338	7%	14%	
94123	Marina	8	14	13	11	9	55	18%	<1%	82%	<1%	306	<1%	1,738	1%	3%	
94124	Bayview-Hunter's Point	331	1,629	1,562	1,221	873	5,616	56%	14%	44%	9%	10,050	9%	9,228	7%	61%	
94127	St. Fi's Wd/Miral/Seaside	16	73	34	40	45	208	24%	1%	76%	1%	849	1%	3,532	3%	6%	
94130	Treasure Island	0	1	3	1	40	45	76%	<1%	24%	<1%	59	<1%	1,862	1%	2%	
94131	Twin Peaks-Cien Park	46	119	102	90	60	417	34%	1%	66%	1%	1,241	1%	4,559	3%	9%	
94132	Lake Merced	60	196	178	163	145	742	37%	2%	63%	2%	1,990	2%	5,333	4%	14%	
94104/11/33	Finan/Telegraph/N Beh/Ctown	116	431	309	230	203	1,289	23%	3%	77%	5%	5,684	5%	4,703	3%	27%	
94134	Visitation Valley	264	1,135	816	603	527	3,345	46%	8%	54%	6%	7,221	6%	10,375	7%	32%	
SUBTOTAL, Residential		2,889	11,270	8,663	7,154	6,310	36,286	34%	91%	69%	93%	106,050	93%	138,695	100%	26%	
SUBTOTAL, Other		193	855	900	831	819	3,598	46%	9%	54%	7%	7,776	7%	-	-	-	
TOTAL		3,082	12,125	9,563	7,985	7,129	39,884	-	100%	-	100%	113,826	100%	-	-	-	
% of Total		3%	11%	8%	7%	6%	35%	-	-	-	-	100%	-	-	-	-	
California		235,213	1,000,524	764,160	567,960	406,033	2,973,890	-	-	-	-	5,296,978	-	-	-	-	
% of Total		4%	19%	14%	11%	8%	56%	-	-	-	-	100%	-	-	-	-	

Source: California Dept. of Health Services, Medical Care Statistics Section, "Medi-Cal Eligibility By Zip Code Table", Medi-Cal Eligibility File, January 1997 ([www.dhs.ca/hvnet.gov](http://www.dhs.ca/hvnet.gov))

1) Zip codes less than 50 per county are categorized as "Other".

2) 94129 = Presidio, with a population of ages 0-18 of 1,477. Data on Medi-Cal eligibles for this zip code was not available.

"Other" zip codes include 94014, 94015, 94044, 94070, 94080, 94119, 94120, 94140, 94141, 94142, 94164, 94188, 94533, 94558, 94591, 94605, 94612, 94804, 94806, 94903. There were no eligibles identified within zip code 94129 (Presidio - population of ages 0-18 = 1,477).

\* "Eligibles" are individuals who have been determined eligible for Medi-Cal benefits

**MEDI-CAL ELIGIBLES AS A PERCENT OF POPULATION,  
AGES 0-20, BY ZIP CODE,  
SAN FRANCISCO, JANUARY 1997**

<u>Zip Code</u>	<u>Neighborhood</u>	<u>Eligibles</u>	<u>Population Ages 0-20</u>	<u>% Medi-Cal</u>
94124	Bayview-Hunter's Point	5,616	9,228	60.9%
94103	South of Market	1,562	3,254	48.0%
94102	Tenderloin/Civic Center	1,952	4,196	46.5%
94115	Western Addition	1,864	4,123	45.2%
94105/7	Rincon/Potrero Hill	1,057	2,346	45.1%
94134	Visitacion Valley	3,345	10,375	32.2%
94110	Inner Mission	5,734	18,253	31.4%
94109	Polk/Russian Hill	1,643	5,577	29.5%
94104/11/33	Finan'l/Telegr'/N.Bch/C'town	1,289	4,703	27.4%
94112	Ingleside-Excelsior	4,070	16,638	24.5%
94108	Chinatown	449	1,897	23.7%
94121	Outer Richmond	1,483	7,527	19.7%
94117	Haight-Ashbury	937	5,495	17.1%
94118	Inner Richmond	1,098	6,721	16.3%
94122	Sunset	1,457	10,338	14.1%
94132	Lake Merced	742	5,333	13.9%
94116	Parkside	1,086	8,227	13.2%
94131	Twin Peaks-Glen Park	417	4,559	9.1%
94114	Castro, Noe Valley	177	2,773	6.4%
94127	St. Fr's Wd/Miral'/Seaside	208	3,532	5.9%
94123	Marina	55	1,738	3.2%
94130	Treasure Island	45	1,862	2.4%
	Other	3,598	-	-
	Total	39,884	138,695	28.8%

Source: California Department of Health Services, Medi-Cal Eligibility By Zip Code, January 1997

Note: Population based on 1990 Census.

**MEDI-CAL ELIGIBLES,  
TOTAL AND SELECTED AID CATEGORIES,  
SAN FRANCISCO AND CALIFORNIA,  
1992-1998**

Date	SAN FRANCISCO					CALIFORNIA				
	Total	PA Total	PA Families	MN Families	MI Children	Total	PA Total	PA Families	MN Families	MI Children
April 1998	99,404	77,025	29,703	6,954	3,232	4,557,958	3,455,196	2,384,835	364,327	210,048
January 1997	105,333	83,033	34,719	7,129	3,474	4,893,285	3,794,857	2,717,846	335,519	219,938
January 1996	110,278	87,834	38,667	7,363	3,476	4,932,177	3,886,943	2,812,318	317,036	200,723
January 1994	113,893	88,745	41,119	9,736	3,774	4,946,460	3,837,072	2,802,795	362,293	196,638
January 1992	103,316	83,545	40,061	7,385	3,007	4,281,998	3,459,185	2,506,408	247,253	146,763
% Change, 1992-1998	-3.8%	-7.8%	-25.9%	-5.8%	7.5%	6.4%	-0.1%	-4.9%	47.3%	43.1%

Source: California Department of Health Services, Medi-Cal Reports, Persons Certified Eligible for Medi-Cal (monthly reports)

Notes: These are the preliminary number of Medi-Cal eligibles. "PA" = Public Assistance; "MN" = Medically Needy; "MI" = Medically Indigent.

**Child Health and Disability Prevention (CHDP) Program,  
Children Screened for Health Assessments and  
Children With "Risk Reduced," By Age Groups,  
San Francisco, 1990/91 and 1996/97**

<u>Age Group</u>	# of Children Rec'd Health Ass'ts		# of Children "Risk Reduced"	
	1990/91	1996/97	1990/91	1996/97
0-1	12,089	9,219	2,805	2,217
2-4	6,008	5,645	1,177	1,161
5-9	3,916	4,020	868	960
10-14	2,528	2,600	637	710
15-20	1,130	1,435	391	482
Total	25,671	22,919	5,878	5,530

Source: California Department of Health Services, Children's Medical Services, Child Health and Disability Prevention Program, Children Screened For Health Assessments and Counts for Risks Reduced, 1990/91 and 1996/97 (based on data from CHDP Confidential Screening and Billing forms)

Note:

"Risk-Reduced" refers to health assessments coded as follows:

- o "3": diagnosis made and treatment started;
- o "4": diagnosis pending and return visit scheduled;
- o "5": referral to another examiner for diagnosis and treatment.

**Child Health and Disability Prevention (CHDP) Program,  
Children Screened for Health Assessments  
and Children With "Risk Reduced," By Race/Ethnicity,  
San Francisco, 1996/97**

<u>Race/Ethnicity</u>	# of Children		
	Rec'd Health Ass'ts	"Risk Reduced"	
	#	#	%
Pacific Islander	226	84	37.2%
Hispanic	7,117	2,227	31.3%
Filipino	576	161	28.0%
Black	2,756	634	23.0%
Asian	5,841	1,335	22.9%
American Indian	98	21	21.4%
White	1,069	207	19.4%
Other	998	240	24.0%
Unknown	4,238	621	14.7%
Total	22,919	5,530	24.1%

Source: California Department of Health Services, Children's Medical Services, Child Health and Disability Prevention Program, Children Screened For Health Assessments and Counts for Risks Reduced, 1990/91 and 1996/97 (based on data from CHDP Confidential Screening and Billing forms)

Note:

"Risk-Reduced" refers to health assessments coded as follows:

- o "3": diagnosis made and treatment started;
- o "4": diagnosis pending and return visit scheduled;
- o "5": referral to another examiner for diagnosis and treatment.

**GOLDEN GATE REGIONAL CENTER.**  
**ACTIVE CLIENTS, AGES 0-18, SAN FRANCISCO COUNTY RESIDENTS,**  
**BY AGE GROUPS AND ZIP CODE,**  
**AS OF JULY 31, 1997**

ZIP CODE	NEIGHBORHOOD	0-36 Months	37 Months - 18 Years	TOTAL
94102	Tenderloin	12	22	34
94103	South of Market	3	12	15
94105	Rincon	0	1	1
94107	Potrero Hill	1	8	9
94108	Chinatown	1	5	6
94109	Polk/Russian Hill	10	22	32
94110	Inner Mission	27	78	105
94111	Telegraph Hill/Embarcadero	1	1	2
94112	Ingleside-Excelsior	33	80	113
94114	Castro, Noe Valley	3	12	15
94115	Western Addition	18	17	35
94116	Parkside	5	36	41
94117	Haight-Ashbury	5	9	14
94118	Inner Richmond	6	12	18
94121	Outer Richmond	4	25	29
94122	Sunset	10	38	48
94123	Marina	5	12	17
94124	Bayview-Hunter's Point	32	33	65
94127	St Francis Wood; Miraloma/Seaside	0	15	15
94129	Presidio	4	1	5
94131	Twin Peaks-Glen Park	8	13	21
94132	Lake Merced	4	15	19
94133	North Beach/Chinatown	2	11	13
94134	Visitation Valley	17	40	57
Other	-	4	10	14
TOTAL		215	528	743

Source: Golden Gate Regional Center, August 1997

Note: "Other" includes 94014, 94018, 94030 (Treasure Island - no clients), 94034, 94044, 94080, 94104 District - no clients), 94553, 94558, 94596, 94928; 3 unknown.





EXT. CASE  
TABS  
2



